

# THE MENTAL CAPACITY ACT 2005 AND THE INSTITUTIONAL DOMINATION OF PEOPLE WITH LEARNING DISABILITIES

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Submitted by Lucy Victoria Series to the University of Exeter as a thesis for the degree of Doctor of Philosophy in Law, January 2013.

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# ABSTRACT

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When people with learning disabilities are ‘placed’ in institutional care services, they are exposed to a range of interferences with their choices and freedoms. These interferences include the imposition of rules and regimes by institutional authorities, surveillance, a loss of private space and encroachments upon bodily integrity such as being subjected to restraint, seclusion and sedating medications, and restrictions may be imposed over their dealings with others within and outside of the institution. As Goffman and others have argued, the cumulative and pervasive effects of these regimes can be monumentally detrimental to self and wellbeing. These interferences have been found across the entire spectrum of care services, even in those which were initially designed to replicate the choices and freedoms of living in one’s own home.

Various writers have expressed the view that a new statute, the Mental Capacity Act 2005 (MCA), is empowering for people with mental disabilities and some have suggested it may be help to ensure such interferences are minimised and occur on a more principled basis. The MCA governs when decisions can be made on behalf of people who lack ‘mental capacity’ in their best interests and when restraint can be used. It also contains a framework for detention called the deprivation of liberty safeguards (DoLS). In this thesis, I make the paradoxical sounding claim that the MCA is not an ‘empowering’ statute, but that the DoLS contain many elements which make them better suited to tackling these types of issues.

The argument advanced in this thesis is based on ideas from new civic republican philosophy (Pettit, 1997; Lovett, 2010). Republican philosophers identify exposure to arbitrary interferences in one’s choices and freedoms with being in a ‘state of domination’. They argue that in order to ameliorate states of domination, social power must be exercised in accordance with clear and well known principles, which are effectively enforced. By showing how they have been variably interpreted by the courts, I argue that the ‘elegant’ and ‘flexible’ principles of the MCA do not adequately constrain the actions of those empowered under the Act. For many of the issues of concern in institutional placements, the legal principles derived from the MCA are barely developed at all.

I examine four mechanisms of enforcement of the MCA, in addition to the DoLS: the Independent Mental Capacity Advocacy Service; litigation in the Court of Protection; complaints mechanisms; and regulation by the Care Quality Commission. I show that each mechanism suffers from a variety of shortcomings. One major problem is a lack of independent scrutiny of the *substantive outcomes* of capacity assessments. Another is

that people with learning disabilities have significant difficulties using the law to challenge decisions made under it, and rely upon 'coat tailing' on disputes which break out between families and professionals to access justice.

Despite suffering from significant shortcomings, I argue that the DoLS contain several important ingredients that could potentially overcome some of these problems. A potential strength of the DoLS is the ability to address whether or not a person is in a service which is appropriate for them, alongside whether their treatment within that service is appropriate. Furthermore, the DoLS can help detainees and their families circumvent some of the 'access to justice' issues they would face if they applied to the Court of Protection under the main provisions of the MCA. Nevertheless, as presently constructed, the DoLS themselves contain too much scope for arbitrary interpretation and application to be a credible solution to the problem of domination.

I argue that radical reforms are required to address these difficulties. On the basis of the republican critique I have subjected the MCA and the DoLS to in this thesis, I argue that reformers must be clear about what interferences are tolerable in the lives of people with learning disabilities. Secondly, there must be appropriate and accessible safeguards to enable people with learning disabilities to assert their rights in the face of arbitrary interferences. I argue that efforts at reform founded upon a 'support paradigm', associated with the UN Convention on the Rights of Persons with Disabilities, still establish a risk of institutional domination which must be constrained. Legal reforms which have been tried have failed because they have never been responsive to the needs and concerns of people with mental disabilities. Reform efforts must be dedicated to the recovery of a legalism that is attentive to their needs and concerns. I offer some suggestions for what a more progressive legalism might look like, based on the lessons from the MCA and the DoLS.

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*This thesis is dedicated to Chris; in grateful thanks for all his love and support.*



# ABBREVIATIONS AND TERMINOLOGY

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<b>ADASS</b>	Association of Directors of Adult Social Services
<b>AMHP</b>	Approved Mental Health Professional. A role under the MHA.
<b>BAILII</b>	British and Irish Legal Information Institution ( <a href="http://www.bailii.org">www.bailii.org</a> )
<b>BIA</b>	Best Interests Assessor. An assessor role under the DoLS.
<b>CAFCASS</b>	The Children and Family Court Advisory and Support Service
<b>care home</b>	Formal care that is provided together with accommodation.
<b>CoPLR</b>	Court of Protection Law Reports (Official series published by Jordans Publishing)
<b>CQC</b>	Care Quality Commission
<b>CRPD</b>	United Nations Convention on the Rights of Persons with Disabilities
<b>CRPD Committee</b>	United Nations Committee on the Rights of Persons with Disabilities
<b>CSCI</b>	Commission for Social Care Inspection
<b>deputy</b>	A person appointed by the Court of Protection under s16 MCA to make decisions on P's behalf in relation with specified matters.
<b>DoLS</b>	Deprivation of liberty safeguards (contained within Schedule A1 of the Mental Capacity Act 2005)
<b>domiciliary care</b>	Care that is provided by an agency to a person in their own home; contrast with 'care home'.
<b>ECHR</b>	European Convention on Human Rights
<b>ECtHR</b>	European Court of Human Rights
<b>EHRC</b>	Equality and Human Rights Commission
<b>EPA</b>	Enduring Power of Attorney
<b>EU</b>	European Union
<b>FRA</b>	European Union Agency for Fundamental Rights
<b>guardianship</b>	In England and Wales, 'guardianship' refers to a little used regime under the MHA 1983 whereby a person is appointed to make some limited decisions regarding a person's residence and connected welfare issues. In international debates, 'guardianship' usually refers to any regime whereby a single person is nominated as a person's legal representative and empowered to make substituted decisions on their behalf.

<b>HCC</b>	Healthcare Commission
<b>HRA</b>	Human Rights Act 1998
<b>IMCA</b>	Independent Mental Capacity Advocacy, a form of statutory advocacy created by the MCA
<b>IRO</b>	Independent Reviewing Officer
<b>JCHR</b>	Joint Committee on Human Rights
<b>LASPO</b>	Legal Aid, Sentencing and Punishment of Offenders Act 2012
<b>legal capacity</b>	Legal capacity has been defined as ‘the capacity to hold a right and the capacity to act and exercise the right’ (Cifuentes et al, 2008). Legal capacity means that a person is recognised as exercising legal agency, and is distinct from ‘mental capacity’.
<b>LGO</b>	Local Government Ombudsman
<b>litigation capacity</b>	Litigation capacity refers to both a person’s ‘legal capacity’ to litigate – their right to conduct legal proceedings without going through a ‘litigation friend’ – and the ‘mental capacity’ a person requires under English law to exercise their legal capacity in connection with litigation.
<b>litigation friend</b>	A litigation friend is a person who is appointed to conduct legal proceedings on behalf of a person who lacks litigation capacity. They are responsible for instructing the person’s solicitor and counsel according to the person’s best interests.
<b>LPA</b>	Lasting Power of Attorney
<b>LSC</b>	Legal Services Commission
<b>MCA</b>	Mental Capacity Act 2005
<b>MDA</b>	Making Decisions Alliance, an organisation which campaigned for the MCA
<b>MDAC</b>	Mental Disability Advocacy Centre, Budapest, Hungary
<b>mental capacity</b>	‘Mental capacity’ refers to a person’s decision making ability, and is defined in s2-3 MCA. Under the MCA, a person’s ‘legal capacity’ depends upon their ‘mental capacity’. It has been suggested, in connection with the CRPD, that a person should be able to exercise legal capacity regardless of their mental capacity.
<b>MHA</b>	Mental Health Act (followed by the appropriate year). Unless otherwise specified, ‘MHA’ refers to the MHA 1983, as amended.
<b>MHAC</b>	Mental Health Act Commission
<b>MHLO</b>	Mental Health Law Online
<b>NAA</b>	National Assistance Act 1948



<b>NGO</b>	Non-governmental organisations
<b>OPG</b>	Office of the Public Guardian
<b>OS</b>	Official Solicitor
<b>P</b>	'P' is a term used in the MCA, DoLS and associated legal materials. P is defined in the Court of Protection Rules 2007 rule 6 as 'any person (other than a protected party) who lacks or, so far as consistent with the context, is alleged to lack capacity to make a decision or decisions in relation to any matter that is the subject of an application to the court and references to a person who lacks capacity are to be construed in accordance with the Act'.
<b>PHSO</b>	Parliamentary and Health Service Ombudsman
<b>PRN</b>	'Pro Re Nata' – refers to medication administered as required
<b>QRP</b>	Quality and Risk Profile. A measure used by CQC to identify higher risk services for more frequent inspections.
<b>SCR</b>	Serious Case Review
<b>SDS</b>	Self Directed Support
<b>SOAD</b>	Second Opinion Appointed Doctor under the MHA
<b>substituted decision-making</b>	A substituted decision occurs where a person's legal capacity to make decisions for themselves is supplanted by the decision of a third party. Under the MCA, 'best interests' decision making is a form of substituted decision making.
<b>supported decision-making</b>	Where a person makes a decision with the support of others, this is a supported decision. Under the CRPD, people with disabilities should be provided with support to enable them to make decisions and exercise their legal capacity.

## A NOTE ON LANGUAGE

Deciding what terminology to use is fraught with difficulty in the field of disability studies. As Luckasson (2003) observes, the process of defining and classifying people according to disability or diagnosis has significant power effects. Some campaigners and scholars prefer to use 'person first' language such as 'people with disabilities', to emphasise personhood first and foremost. This approach is reflected in the language of the UN Convention on the Rights of Persons with Disabilities. However, those familiar with the British Social Model often prefer the phrases 'disabled people' or 'disabled person', to emphasise that people are actively disabled by society. Some people associated with the neurodiversity movement have expressed a preference for this

approach, regarding autism or other conditions are central to – and inseparable from – their identities (Sinclair, 1999; Winegardner, 2010). Both phrases are used in this thesis interchangeably, because I do not regard the sentiments underpinning preferences for person-first and ‘disabled person’ terminology as incompatible.

There is also little consensus on the preferred terminology for those whom I have called in this thesis ‘people with learning disabilities’. Many, especially those involved in international debates, prefer the term ‘intellectual disabilities’. I have deliberately chosen the term ‘learning disabilities’ in this thesis over ‘intellectual disabilities’ for two reasons. The first is because this is the term used in legal instruments and policy materials in England and Wales to pick out this group. The second is because I have encountered the phrase ‘intellectual disabilities’ being used more broadly than ‘learning disabilities’, to pick out people with other cognitive impairments. Whilst I share the revulsion of authors like Luckasson for the phrase ‘mental retardation’, I have encountered little to suggest the phrase ‘learning disabilities’ as it is used in England and Wales meets with such antipathy.<sup>1</sup> I have also used the phrase ‘mental disabilities’ to refer to a wider group of people with cognitive impairments and psychosocial disabilities of all kinds, as much in this thesis that concerns mental capacity and mental health law is relevant to them.

I use the term ‘solicitor’ throughout this thesis to describe the professional who conducts proceedings on behalf of a client, and who may instruct counsel to represent them in court. I recognise, however, that many excellent and able legal representatives are legal executives and not solicitors. I hope they will forgive me for using the term ‘solicitor’ to refer to them also, in order to avoid excessive cluttering of the text of this thesis.

## REFERENCES AND CITATIONS

In the main I have used Harvard style referencing for all articles, books and reports etc. However, for case law and statutes I have used guidance from the Oxford Citation Standards (OSCOLA). Please note that for many judgments referenced in this thesis, standard citations are not available; information on citation schemes and sources of Court of Protection judgments is given in Chapter 3.

Where paragraph numbers are available for cases or other references, I have put them in square brackets; [2], for paragraph number 2.

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<sup>1</sup> American readers may be more familiar with the term ‘learning disabilities’ being used to describe conditions like dyslexia; in England these are more commonly called ‘learning difficulties’ and are distinct from learning disabilities as the phrase is used in this thesis. Self-advocacy organisations like People First, and Cardiff People First, use both ‘learning disabilities’ and ‘learning difficulties’.

'To exercise power over another, in a sort of open strategic game, where things could be reversed, that is not evil. That is part of love, passion, of sexual pleasure. Let us also take something that has been the object of criticism, often justified: the pedagogical institution. I don't see where evil is in the practice of someone who, in a given game of truth, knowing more than another, tells him what he must do, teaches him, transmits knowledge to him, communicates skills to him. The problem is rather to know how you are to avoid in these practices - where power cannot not play and where it is not evil in itself - the effects of domination which will make a child subject to the arbitrary and useless authority of a teacher, or put a student under the power of an abusively authoritarian professor, and so forth. I think these problems should be posed in terms of rules of law, of relational techniques of government and of ethos, of practice of self and of freedom.'

Foucault (1987: 129)



# CHAPTER 1 – INTRODUCTION

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## 1.1 INTRODUCTION

On a series of spring days, several years ago, I tied a rope around the waist of a man and took him for a walk. An agency had sent me to a small care service for adults with ‘severe’ learning disabilities and autism, and this was among the first tasks I was given. My sense of discomfort at being given, and performing, that task has not eroded over the years. I rehearsed counterfactuals: that without the rope he had been known to run off towards roads and other risks he was unlikely to understand, and faster than the staff. Without the rope he might ingest inedible, potentially toxic, items that he saw. Without the rope, a walk would not be permitted at all. Yet there was more to holding a man on the end of a rope than preventing exposure to these risks: the potential to disrupt any freely chosen act of his was ever present. Every movement of his, every action from the point at which the rope was fitted, occurred *because it was permitted* by the person holding it. The person holding the rope was subject to an expectation to control; one might be called to account for any action of his.

In less extreme forms this awkward power relation of care and control played out repeatedly during the years I worked in social care. It underpinned naggings and prohibitions against eating ‘bad’ foodstuffs; restrictions on the use of private spaces in order to prevent people enjoying sexual relations; discouragement or prohibitions of drinking and smoking. In a service operated by an intentional community it underpinned a ban on television watching except for specified programs one night of the week (except for staff, who could watch anything, at any time). In another service, it underpinned a decision not to let a man purchase a mobile phone with his own money, ‘in case he rang people with it’. In another, to prevent a man from pursuing his desire to have driving lessons. It underpinned rules that bedrooms must be tidied, institutional timetables adhered to, staff directions obeyed. In many of these services, sociologist Erving Goffman’s (1961: 43) description of life in what he called a ‘total institution’ rang horribly true:

...minute segments of a person's line of activity may be subjected to regulations and judgements by staff; the inmate's life is penetrated by constant sanctioning interaction from above... The autonomy of the act itself is violated.

Goffman described the effect of this penetrating and constant sanctioning from above as ‘mortification of the self’.

In contrast with the dramatic incursions into autonomy which often characterise medical interventions, the creeping loss of autonomy in everyday life that is experienced in social care settings may seem banal and of lesser importance. Yet researchers have found that loss of control over one's environment and routines in social care settings makes measurable contributions towards mental illness and depression (Boyle, 2005), and declines in alertness, participation and wellbeing (Langer and Rodin, 1976). The cumulative and pervasive loss of freedoms in long term institutional care raises profound existential and ethical concerns (Collopy, 1990; Hacking, 2004). Amanda Baggs (2012b), an autism rights campaigner and survivor of several institutions, puts it thus:

The cause of the problem is a certain exercise of power. Of person over unperson. And in order to survive it the inmates have to become as much of that unperson as they can manage. And that does violent damage deep inside the self, that can be incredibly hard to repair. It's violent even when it comes with purported love and sweetness and light.

This thesis is concerned with the problem of domination, and its concomitant assault on autonomy and identity, in institutional care for adults with learning disabilities. Using a critique drawn from new republican political philosophy, it examines whether a new law, the Mental Capacity Act 2005 (MCA), can help to address this problem.

## 1.2 THE MENTAL CAPACITY ACT 2005 AND THE PROBLEM OF DOMINATION

When the government passed the MCA, it seemed to some of us working in care services that it would offer adults with learning disabilities greater control over their own lives. The code of practice states that the Act was intended to 'empower' adults with mental disorders and 'to discourage anyone who is involved in caring for someone who lacks capacity from being overly restrictive or controlling' (Lord Chancellor's Office, 2007: foreword, [1.4]). The Act has been widely celebrated as promoting autonomy (Boyle, 2008a: 303-4; 2008b; Johnston and Liddle, 2007), as 'empowering' (Manthorpe et al., 2009), 'restoring power' (Social Care Institute for Excellence, 2009), or as protecting or enshrining 'rights' to make choices in people's lives (Antaki et al., 2008; 2009; Badger and Parnell, 2009). The Care Quality Commission (CQC) has suggested that the MCA is 'the most promising lever yet' to eradicate 'the easy and careless preference for restrictive practices' which have been an enduring feature of the care of adults with learning disabilities (Care Quality Commission, 2012f: 12). From these perspectives, the MCA appeared to have in its sights these penetrating and all encompassing relationships of control, to which adults with mental disabilities are all too often subject in the name of care. Yet, this thesis will argue, despite these appearances it is unclear that the MCA

has achieved, can achieve, or was even designed to achieve, the resolution of these kinds of problems around care and control.

The MCA establishes a legal framework for interferences with the choices and freedoms of adults with mental disorders. Its first principle – known as the ‘presumption of capacity’<sup>2</sup> – requires that people are afforded the same choices and freedoms as anybody else unless it is established that they ‘lack capacity’<sup>3</sup> in relation to a particular matter. Under the MCA, any interference with a person’s choices or liberty that is grounded in incapacity must be in that person’s ‘best interests’.<sup>4</sup> Those making decisions about best interests must give consideration to the least restrictive option.<sup>5</sup> The Act introduced requirements for proportionality and necessity in the use of restraint.<sup>6</sup> The Act has complex relationships with the common law, public law and human rights law, which serve both as sites for its application and shape its interpretation.

The code stipulates that the Act covers a wide range of issues affecting adults with learning disabilities, from decisions about where they live and medical treatments, to day to day decisions about how they live their lives.<sup>7</sup> However, despite a widespread belief that the MCA regulates ‘small acts of care’ (Stanley and Manthorpe, 2009; Samsi and Manthorpe, 2013), its relevance to the kinds of day to day issues that typify the creeping loss of freedom and control in institutional life is less clear-cut when one examines its mechanisms in detail. The MCA also contains a framework for detention on mental-capacity related grounds, known as the deprivation of liberty safeguards (DoLS). Unlike the main provisions of the MCA, the DoLS have proven extremely unpopular and have been subject to a range of criticisms. Yet, this thesis makes the paradoxical sounding claim that this framework for detention secures liberty more effectively than the main mechanisms of the MCA.

In its first few years, the MCA has proven to be a remarkably popular Act. Criticisms which have been levelled at the Act have tended to focus on problems with its implementation or interpretation. Several studies have raised concerns about understanding or application of the statute by care providers (Badger and Parnell, 2009; Care Quality Commission, 2011i; 2012d; g; Manthorpe et al., 2011), health and social care professionals (Williams, V. et al., 2012; Samsi et al., 2011; Emmett et al., 2012; Willner et al., 2011; Donnelly, 2009a;b; Donnelly, 2011) and family carers (Manthorpe et

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<sup>2</sup> s1(2) MCA ‘A person must be assumed to have capacity unless it is established that he lacks capacity.’

<sup>3</sup> Through application of the definition given in ss2-3 MCA.

<sup>4</sup> Determined by reference to the checklist given in s4 MCA.

<sup>5</sup> s1(6) MCA

<sup>6</sup> s6 MCA

<sup>7</sup> See paragraphs [1.1], [1.8], [1.8], [3.3], [5.58], [6.1], [4.38], [4.60], [5.27] and [5.60] (Lord Chancellor's Office, 2007).

al., 2009; Manthorpe et al., 2012; Redley et al., 2012; Stanley and Manthorpe, 2009). Some, especially those writing in the field of medical ethics, have disputed the interpretation of best interests in particular judgments.<sup>8</sup> Some have argued that the principles for consent to treatment and detention under the MCA are more desirable than the Mental Health Act (MHA), and the two schemes should be ‘fused’ together (Dawson and Szmukler, 2006; Szmukler et al., 2011; Szmukler and Holloway, 1998), although responses to this proposal are varied (Appelbaum, 2010; Atkinson and Patrick, 2011; Burns, 2011; Gledhill, 2010; Padfield, 2011; Robinson, 2011; Skipworth et al., 2012; Szmukler et al., 2011). Some have praised the Act’s liberal credentials, balanced with more protective considerations (Coggon, 2008a; 2008b).

Overall, criticisms of the structure and principles of MCA have been few and far between. White and Baldwin (2006: 388) criticised the Act for being ‘lengthy and cumbersome’ and ‘quintessentially “New Labour”, in that it changes the law very little, but redistributes decision-making power to government and the courts’. There has been surprisingly little commentary on features of the MCA that give health and social care professionals considerable powers in contrast with disabled people and their families. This may be because it is chiefly people with professional backgrounds who have written commentaries on the Act and they are oblivious to, or satisfied with, this state of affairs.<sup>9</sup> Indeed, some medical professionals have complained the Act does not give them *enough* power and have called for a person’s chosen proxy decision makers to be demoted to mere ‘advisors’ to professionals (Wrigley, 2007).

Some have complained that the construction of best interests and capacity under the Act is too vague, and requires further guidance for particular types of decisions (Hope et al., 2009); a criticism with which I concur. Very few ethicists, medical or social work professionals have taken issue with the core concept of the Act: that some people lack ‘mental capacity’ and the decisions of others should be substituted for their own. There have been various debates around the best interests standard, with some suggesting that it is discriminatory towards disabled people or overly deferent to medical opinion (Diesfeld, 2001; Veatch, 2000). Some critics have pointed out that the ‘capacity standard’ is neither especially scientific nor objective (Veitch, 2006; Banner, 2012b). With the exception of Szasz (2005), however, few writing in the traditions of professional

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<sup>8</sup> In particular, an entire industry appears to have sprung up commentating on the case *W v M* [2011] EWHC 2443 (Fam). Commentaries discuss whether or not a person’s prior expressed views regarding life-sustaining treatment should carry more weight than their perceived quality of life, whether a person in a minimally conscious state has any quality of life, and what the resource implications of sustaining their life might be (Gillon, 2012; Huxtable, 2012; Jackson, 2012; Mullock, 2012; Sheather, 2012b; a).

<sup>9</sup> This will be discussed in more detail in Chapter 3.



or medical ethics have suggested we should abandon the concept of incompetence altogether.

Perhaps it says a great deal about the culture of care services that the core principle of the MCA – that people should be afforded maximum autonomy in accordance with their ‘mental capacity’ – struck me as revolutionary when I first heard of the Act, and still strikes many as empowering. However, for many people in the disability rights movement, the MCA does not go nearly far enough. Article 12 of the UN Convention on the Rights of Persons with Disabilities (‘CRPD’, United Nations, 2006a) – the right to equal recognition before the law - has provoked heated international debate about ‘legal capacity’. Article 12 CRPD calls for people to be given the support they need to exercise their legal capacity. Some have interpreted Article 12 to mean that it may never be permissible to interfere with a person’s choices and freedoms on disability related grounds in the way the MCA permits (Centre for Disability Law & Policy, 2011; Dhanda, 2006-7; Minkowitz, 2006-7). Even the more circumspect interpretations have suggested that the MCA may not be compatible with the UN CRPD (Bartlett, 2012b; Richardson, 2012; Lush, 2012). The concluding observations of the UN Committee for the Rights of persons with Disabilities to date suggest that regimes of ‘substituted decision making’, of which the MCA is one variety, are prohibited by the UN CRPD. These CRPD-inspired critiques of the substantive principles which underpin the MCA are deeply thought provoking and deserve careful consideration, yet they do not form the basis for the reasons the MCA is criticised here. However, the debates around Article 12 CRPD will be revisited in more detail in Chapter 4, as the history and aims of the drafters of the CRPD form a striking contrast with the origins of the MCA and its surrounding claims of ‘empowerment’.

### 1.2.1 A REPUBLICAN CRITIQUE OF THE MENTAL CAPACITY ACT 2005

This thesis accepts at the outset a point that some would heavily contest – that in some, very limited, circumstances it is very hard to see how to proceed without a mechanism that permits a person’s present actions or choices to be overridden. However, there are two central problems with the way the MCA permits this to occur:

The central principles of the MCA are very vague, leaving people exposed to arbitrary interferences with their choices and freedoms from a wide range of actors.

Even if the principles were well defined, the machinery for enforcing the principles of the MCA is weak, inaccessible and itself subject to arbitrary application.

Consequently, the MCA permits a proliferation of possible interferences, many of them linked to the problems of institutional domination described above, whilst offering few realistic avenues to challenge them. Whilst the MCA is in many ways a protective and paternalistic statute, which contains mechanisms designed to limit and constrain risks, this thesis argues that it does so in a way which exposes people to a different economy of risks, which are less frequently acknowledged.

Exposure to arbitrary interferences in one's choices and freedoms is described within new republican political philosophy as a 'state of domination' (Pettit, 1997b; Lovett, 2010b). Republican approaches to liberty differ in several important respects from other traditional and contemporary approaches to liberty in political philosophy. Republicans are concerned with non-domination, not non-interference. Interferences with a person's choices and freedoms, even quite considerable interferences, are acceptable to republicans so long as they are principled and not subject to the whims or caprices of those exercising power. For example, republicans would regard children as capable of enjoying liberty, albeit that they might be subject to quite considerable interferences by their parents and teachers, so long as these interferences were principled and non-arbitrary (Pettit, 1997b: 119-120). By contrast, traditional liberal writers have tended to exclude children and people with mental disorders<sup>10</sup> from the bounty of the liberal project, on the basis that they lack attributes of 'maturity' or rationality (Kant, 1886; Mill, 1859/2005). Brennan and Hamlin (2001) contrast 'liberal liberty' as a state of affairs which one can in principle enjoy in isolation, since one will be free of interferences by third parties, with republican liberty which is an attribute of an institutional structure which individuals can enjoy non-dominating relationships. Contrasts between republican liberty and traditional liberalism, as well as certain other important concepts related to liberty, will be explored in more detail in Chapter 2.

Contemporary republican theory is closely associated with the work of Philip Pettit (1997b: viii), whose inspiration for the idea of freedom as non-domination arose from his own experiences of living in a 'total institution':

...it made sense of my experience when, intending to be a priest, I had spent years in establishments that I learned later to describe, in Erving Goffman's phrase, as total institutions... [T]hey communicated a sense of systematic vulnerability and exposure to the governing will, sometimes

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<sup>10</sup> Amongst others; Kant (1784) also excluded women from his project of Enlightenment, whilst Mill (1859/2005: 13-14) also excluded 'those backward states of society in which the race itself may be considered as in its nonage'.

even making a virtue of the practice... Our formation had tried to cultivate unfreedom; it was designed to make students passive, unassertive, unsure of where they stood. Mary Wollstonecraft wrote in the 1790s of the way that women's subordination turned them into creatures who learned to bow and scrape, and to achieve their ends by ingratiation. She might have been writing of us.

My own experiences of working in 'total institutions' in social care suggests that people with learning disabilities are very often exposed to the whims and caprices of the 'governing will' in just the way in which Pettit describes. In Chapter 2 I will review research and 'grey' literature which supports this contention, and elaborate on the concrete manifestations of this particular form of 'institutional domination' in more detail. This thesis considers whether the MCA can cultivate a space of non-domination, where adults with learning disabilities can be more certain of where they stand in such settings and less subject to arbitrary interferences with their choices and freedoms. Despite having high hopes for the potential of the MCA to do so when I embarked upon this research, my conclusion is that – disappointingly – it does not.

### 1.3 LEGALISM, DISCRETION AND ARBITRARINESS

The MCA is merely the latest iteration in a long series of legal efforts to regulate the 'care' and control of people with mental disabilities in Madhouses, asylums and other institutions which people with mental disabilities have been confined to, which burgeoned during modernity. This 'turn to law' to impose control over the exercise of control is often referred to as 'legalism'. A countermovement away from using legal and regulatory machinery to constrain the decisions and actions of those exercising control in the name of protection is sometimes described as 'informalism'. The history of mental health law is sometimes described as cycles, or a pendulum swinging, between extremes of legalism and informalism (Bowen, 2007; Fennell, 1996; Gostin, 1983a; Jones, K. 1980; Unsworth, 1987).

Two particular concerns have recurred over the centuries regarding institutional care, described by Thomas Townsend in a House of Commons report on the conditions in Madhouses in 1763 as:

1. The manner of admitting persons into houses now kept for the reception of lunatics; and
2. The treatment of them during their confinement.

In these twin foci Townsend intuited that there was a connection between the manner in which a person came to live in a particular place and whether or not they could

subsequently leave it, and how they were treated whilst confined therein. These twin concerns led to the genesis of two aspects of legalism: efforts to control the arbitrariness of admissions to institutions, usually in the form of detention safeguards, and efforts to control practices which occurred within those institutions, usually through some form of licensing and regulation, or visitation. Both these elements were established to some degree in the Madhouses Act 1774 (14 Geo 3 c 49), which eventually followed Townsend's report, and both are present to some degree in the MHA 1983 and associated health and social care statutes.<sup>11</sup>

Legalism reached its zenith with the Lunacy Act 1890 (53 Victoria c 5), but fell out of favour during the 20th Century following the Percy Commission's recommendations for a more 'informal' approach, resulting in the Mental Health Act 1959. The contrast between the two is striking. Whereas the Lunacy Act 1890 required a judicial order prior to the admission of a 'lunatic' to any institution,<sup>12</sup> the MHA 1959 placed the judicial safeguard after admission, to be triggered by an application to a Mental Health Review Tribunal. Although the 19<sup>th</sup> century Lunacy Acts made some limited provision for 'voluntary' boarders in licensed establishments without the need for judicial authority or medical certification, this was not widely used (Fennell, 1996). By contrast, the Percy Commission recommended that those who were not objecting to their confinement should not be subject to formal powers of detention, resulting in a growing number of people who were 'informally' admitted to hospital without any of the safeguards of the MHA 1959 (Lord Percy, 1957). From the Madhouses Act 1774 until the MHA 1959 it was an offence for anyone to keep a house for the reception of more than one 'lunatic' without a license (Roberts, 1981a: section 1.2.1). The various licensing authorities from 1774 until 1959<sup>13</sup> were responsible for visiting establishments and monitoring the conditions within. The MHA 1959 abolished dedicated independent monitoring of mental health facilities. Hale (2011: 1) has described the MHA 1959 as 'little short of revolutionary', and comments that 'the new law was just as liberating for the psychiatrists as it was for their patients'.

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<sup>11</sup> In particular, the Health and Social Care Act 2008 contains provisions for the regulation of health and social care services, including monitoring functions for the MHA and the DoLS.

<sup>12</sup> Excepting 'Chancery Lunatics', whose care was managed by the Court of Chancery.

<sup>13</sup> Roberts (1981a) lists these as follows: In London – the Physician Commission (established 1774); The Metropolitan Commission (established 1828); The Lunacy Commission (established 1845); the Board of Control (established 1913); the Ministry of Health (established 1946). For the rest of England and Wales, Roberts gives Justices of the Peace as the licensing authorities for Madhouses, between 1774-1959. During the nineteenth century there were also moves towards regulation of asylums by poor law medical officers, which the Lunacy Commission perceived as a threat to their authority (Bartlett, 1998: 423).

By the late 20<sup>th</sup> century the pendulum had begun to swing back towards legalism.<sup>14</sup> Growing concern about the rights of mental health patients (Gostin, 1983a; b) and a wave of scandals in long-stay mental hospitals (Roberts, 1981b) contributed towards calls for better legal and regulatory protections for patients. The resultant MHA 1983 'represented something of a return to the civil liberties approach' (Law Commission, 1991: [3.5]). It re-established a dedicated monitoring body for mental health facilities in the Mental Health Act Commission (MHAC) – whose functions are now absorbed into the CQC. Powers for detention and reception into guardianship – a community based form of control – were further restricted under the MHA 1983, and new procedural safeguards for consent to treatment were introduced. The MHA 2007 amended the MHA 1983<sup>15</sup>; Hale (2011: 12) describes these amendments as 'broadening the scope of possible control over their patients.'

Contained within these broader swings of the pendulum of legalism regarding 'mental health' care is a more complex story of the care and control of adults with learning disabilities. This story will be given in more detail in Chapter 2, but its primary significance lies in the fact that in general adults with learning disabilities today are not subject to formal powers of detention or guardianship under the MHA 1983.<sup>16</sup> The majority of adults with learning disabilities in England and Wales in the early 21<sup>st</sup> century live in 'the community', either with their families (38%), in care homes (22%), in 'supported living' accommodation (16%) or as tenants in accommodation provided by local authorities and housing associations (12%), (Mencap, 2011). This thesis is

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<sup>14</sup> This thesis will not devote significant space to the history of legalism and mental health institutions, however several compelling histories of this period are available. Roberts (1981a) details the history of the various licensing and monitoring conditions for Madhouses and asylums. Fennell (1996) describes the history of various aspects of consent to treatment in mental health care. Scull (1977; 1979; 1993) gives a credible Marxist account of the growing use of institutions as a form of social control of 'deviant' populations in modernity. Bartlett (1993; 1998; 1999) describes the care of 'lunatics' in Workhouses during the 19th century, and tensions between centralised and regional sources of authority over their care. Boyle (2002) discusses the historical development of the diagnosis 'schizophrenia' and attempts to locate the basis of mental illness in physiology; she argues that schizophrenia, and by extension many other mental disorders, are social constructs. Castel (1988) examines the rise of psychiatry in 19<sup>th</sup> century France. And, of course, Foucault (2001/1961) describes the evolution of the concept of 'madness' through the Renaissance, Enlightenment and modernity and argues that psychiatry should be understood as more correctly claiming moral not 'scientific' authority.

<sup>15</sup> Henceforth, references to MHA 1983 refer to the MHA 1983 as amended by the MHA 2007.

<sup>16</sup> The NHS Information Centre for Health and Social Care (2012e: Table 4) indicates that in 2011-12 fewer than 1% of detentions under Part II MHA (Compulsory admission to hospital) gave learning disability as the primary reason for detention, and fewer than 6% for Part III (Patients Concerned in Criminal Proceedings or Under Sentence). Mencap (2011) estimate that only around 1% of people with learning disabilities are accommodated in long-stay healthcare services. Official statistics do not give the proportion of people with learning disabilities subject to guardianship under the MHA, but the overall number of people subject to guardianship is extremely low – only 331 new cases were recorded in 2011-12 (NHS Information Centre for Health and Social Care, 2012d: 4).

primarily concerned with the situation of those living in care homes and 'supported living' accommodation, as they have considerable 'institutional' qualities. For these populations, an 'informal' approach to care is still preponderant, and the MCA and the DoLS represent the most significant recent concessions towards regulating issues around confinement and control.

Situating the MCA within this history of legalism is not straightforward. By creating principles and procedures of sorts for the involuntary admission of people who 'lack mental capacity' to institutions, and a framework for their treatment within them, the Act bears some of the hallmarks of legalism. However, the MCA was heavily influenced by an 'informal' approach to legal regulation from the outset (Law Commission, 1991: [4.14]-[4.20]), and consequently contains far fewer of the procedural, juridical and regulatory safeguards that characterised the Lunacy Acts and the MHA 1983. By contrast, the MCA's associated framework for detention – the 'deprivation of liberty safeguards' (DoLS) – does attempt to impose procedural and juridical safeguards against arbitrary interferences with liberty. The parallel development of two legal frameworks seeking to impose almost identical substantive principles – one with a general absence of 'formal' safeguards, and one with perhaps a superfluity of them – offers an opportunity to explore wider issues around the use of law to secure individual freedoms.

Debates about the role of legalism in the care and control of adults with mental disorders have accompanied these swings of the pendulum. Professor Kathleen Jones' critique (1980) of the 'legal approach' to mental health pits it against an 'open-textured'<sup>17</sup> informal approach, which affords professionals maximum discretion in mental health care. She argues that 'We have to face the fact that there are some things which the Law cannot do', and in particular it 'cannot prescribe in detail for such difficult and unhappy situations' as the actual conditions that doctors work in and which patients and their relatives experience (p 12-13). Legal formalism, she argues, has been tried and has failed, and the law could not contain or negate the 'vicious subculture' and abuses which have occurred because of deteriorating morale and conditions of work in hospitals (p14). Larry Gostin (1983a), a former legal officer for the mental health NGO Mind, who was at the forefront of campaigning for the 'new legalism' of the MHA 1983, criticises Jones' arguments as directed against a legal formalism associated with the Lunacy Laws 'that few would support' today (p48). Gostin acknowledges that 'law has not succeeded in trying to prescribe in detail the circumstances in which compulsory psychiatric intervention is justified' (p48), but counters that:

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<sup>17</sup> A term which Jones has borrowed from H.L.A. Hart (1961/1997: 127).

...where decisions involve the removal of a person's liberty or some other right of self-determination, it is no answer to say that the law should not control this activity because there are no reliable and consistent factors which could govern such decisions. If this were the case, the remedy would not be to leave medical discretion unfettered; rather, it would suggest that the discretion should not be exercised at all, and certainly not under the authority of law.

This exchange between Jones and Gostin can be seen as a microcosm of wider debates around how far law can constrain the discretion of those in positions of authority without leading to overly-rigid rules and procedures which cannot prescribe for the particulars of real life situations. It also touches upon important debates about the degree to which law can achieve the emancipatory or transformative ends desired by reformers. These are issues which recur throughout this thesis, and their wider theoretical context will be described in more detail in Chapter 2.

## 1.4 CHAPTER OUTLINES

This 'turn to law' to impose control over those who exercise control, embodied by Gostin's 'new legalism' and earlier forms of 'legalism', is endorsed by republican political philosophers. Pettit (1993; 1997a; b) and Lovett (2010a) both identify the 'rule of law' as an important ingredient of securing republican liberty. This is because, in theory at least, law can contribute towards:

- Clearly defined, well known, principles for the exercise of social power;
- Effective, independent, mechanisms of enforcement for those principles.

However, the republican quest for non-arbitrariness extends beyond the traditional realm of the rule of law, well into the 'private sphere' (Lovett, 2010a: 99). As an Act which purports to regulate down to the microdetails of caregiving, even in informal and non-state caregiving relationships, the MCA does potentially penetrate the private sphere to a quite remarkable degree. This thesis is concerned with how far republican liberty is secured for adults with learning disabilities by the MCA in two important respects:

1. Reducing arbitrariness in admissions to institutions;
2. Reducing arbitrariness in interferences with their everyday choices and freedoms by institutional authorities.

In Chapter 2 I give a more detailed discussion of the current predicament of adults with learning disabilities in institutional care in England and Wales. I provide a short historical overview of policies aimed at community based living and

deinstitutionalisation, and explain the legal status of the different kinds of services people with learning disabilities typically live in today. Drawing from a review of the research and 'grey' literature on restrictive practices in care settings I set out a particular range of concerns that have been raised in connection with institutional care. Because these concerns are primarily directed towards the *arbitrariness* of interferences by institutional authorities, I call them 'institutional domination'. I then go on to review literature on new republican philosophy, exploring some key distinctions with other forms of liberty found in political theory. I explain why republican approaches are especially well suited to describing the predicament of people with learning disabilities in institutional care, and the republican 'prescription' for addressing this problem. I also set out some limitations of republican approaches. I then consider a broader literature which critiques the 'turn to law' for tackling the oppression of oppressed groups. I argue that whilst these concerns are well founded, there are still reasons for believing we should not abandon legal efforts altogether.

In Chapter 3 I outline a bespoke research method which I have adopted to examine the MCA through the lens of republican political theory. This involved using traditional doctrinal methods to examine how far the common law has prescribed clear and well known principles for the key elements of the MCA, and then using a range of techniques to consider how effectively these principles are enforced. I describe how I have used research interviews, requests made under the Freedom of Information Act 2000 (FOIA) and a series of 'micro studies' of reports by the CQC and ombudsmen to look at mechanisms of enforcement. I consider the limitations of the method I have adopted, and discuss why I have not used other research methods which would have offered complementary insights into the issues considered in this thesis.

In Chapter 4 I examine the 'structural pillars' of capacity and best interests under the MCA, and question how clear and consistent the principles for their application and interpretation are. I begin by showing how these 'structural pillars' emerged in the common law, and how they were built into the MCA during its lengthy passage from the Law Commission's research onto the statute books. I question how far these principles, and the MCA as a whole, were ever directed towards 'empowerment', and contrast the development of the MCA with that of the CRPD. I then go on to review case law on the meaning of 'capacity' and argue that the courts have interpreted it in an arbitrary fashion, and various unacknowledged normative criteria have seeped into its analysis. I then consider how far the courts have provided clear and consistent criteria for the kinds of interferences that characterise 'institutional domination', which were outlined in Chapter 2. I find that although the courts have developed a considerable body of law relating to conflicts between families and professionals, there are only a few limited signs of the



courts addressing the problems of 'institutional domination' which affect people with learning disabilities alone. I conclude that the MCA has not satisfied the republican criteria of providing clear and well known principles to constrain the exercise of institutional authority over people with learning disabilities, and significant scope for domination remains.

In order to ameliorate states of domination, republicans require effective, independent, mechanisms of enforcement for principles constraining permissible interferences. In Chapter 5 I examine four key mechanisms of enforcement of the MCA in close detail, and ask how independently and effectively they enforce its provisions. These are: the Independent Mental Capacity Advocates (IMCAs); applications to the Court of Protection to resolve disputes over capacity and best interests; complaints to the Local Government Ombudsman (LGO); and regulation by the CQC. I find that each mechanism suffers from a variety of shortcomings, including: a lack of independent scrutiny of the substantive outcomes of capacity assessments; problems with accessing or triggering various mechanisms of enforcement; and the problems people with learning disabilities experience in accessing the Court of Protection without 'coat tailing' on disputes which break out between families and professionals. I argue that this may explain why Court of Protection case law is so skewed towards those kinds of disputes. I also argue that radical reforms of the Court of Protection are required to address these difficulties.

In Chapter 6 I examine one final mechanism of enforcement for the principles of the MCA: the DoLS. Despite the unpopularity of the DoLS, I argue that they contain several important ingredients that can overcome some of the shortcomings of the mechanisms of enforcement described in Chapter 5. In particular, the DoLS potentially provide independent scrutiny of both admission to care services, and the accrued loss of freedoms a person may experience within those services. Consequently, the DoLS are better placed than most other mechanisms to address both elements of the problem of institutional domination – admission, and treatment - simultaneously. Furthermore, the DoLS can help detainees and their families circumvent some of the 'access to justice' issues they would face if they applied to the Court of Protection under the main provisions of the MCA.

However, the DoLS do suffer from several significant shortcomings. Due to their complexity, they are poorly understood and poorly implemented. There are problems with the independence of assessments of capacity and best interests by DoLS assessors, and the important role envisaged for IMCAs appears not to be functioning as it should. The evidence suggests that detainees experience serious difficulties accessing the Court of Protection to exercise their right to appeal under Article 5(4)

European Convention on Human Rights (ECHR), and some of the reasons for this will be discussed. One key issue underpinning the problems with the DoLS is uncertainty over the meaning of 'deprivation of liberty' itself; I argue that the courts have sought to constrain the application of the safeguards because of the strain on resources posed by legalism itself.

I discuss the findings of this research in Chapter 7. I review the reasons given by professionals and reformers alike for rejecting legalism as a way of improving conditions for people with disabilities in institutional care. I offer an argument, based on the findings of Chapters 4 to 7, for approaching calls to turn away from 'legalism' with some caution. On the basis of the republican critique I have subjected the MCA and the DoLS to in this thesis, I argue that reformers must address what interferences they are prepared to tolerate in the lives of people with learning disabilities<sup>18</sup>, and how they will be able to assert their rights in the face of arbitrary interferences. I highlight some areas of concern around proposals for the reform of legal capacity laws, which are not attentive to these issues. I argue that efforts at reform founded upon a 'support paradigm' still establish a risk of institutional domination that must be constrained. I argue that legalism has been tried and has failed because it has never been responsive to the subjectivity of people with mental disabilities. Reform efforts must be dedicated to the recovery of a legalism which is responsive to their needs and concerns. I offer some suggestions for what a legalism of the future might look like, based on the critique of the MCA and DoLS outlined in this thesis.

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<sup>18</sup> I do not mean by this that such permissible interferences should be framed in a disability-specific way; these may be interferences that would be tolerable for *any* persons.

# CHAPTER 2 - INSTITUTIONAL DOMINATION

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## 2.1 INTRODUCTION

One way of thinking about the kinds of oppression that people with learning disabilities experience in institutional care services is as a form of 'domination'. Domination is an idea that is developed in new republican political philosophy, although it can be traced back to ideas from classical antiquity (Skinner, 1997), and has some important parallels with the idea of the 'rule of law'. Domination is not the only way of thinking about the forms of oppression or unfreedom people with learning disabilities may experience in care services. However, I suggest it is a particularly useful way of thinking about their experiences for the purposes of evaluating whether the Mental Capacity Act 2005 (MCA) can ameliorate their situation.

The first part of this chapter will set out in more concrete detail which aspects of life in care services, which are well evidenced in the research and grey literature, I am referring to when I speak of the problems of 'institutional domination'. This section will also give some legal and policy background, which is important for understanding the kinds of institutions adults with learning disabilities live in today. The second part of this chapter will give a more detailed description of new republican political philosophy. The key elements of domination will be discussed, and republican liberty will be contrasted with some other kinds of liberty found in political philosophy which are important, but distinct from the kind of liberty under discussion in this thesis. Finally, in part three, some critiques of using legal strategies for social and political transformation will be considered. I will argue that whilst these are important considerations to bear in mind when evaluating how effective the MCA is in ameliorating states of domination, they are reasons for working to improve legal strategies, not abandoning them altogether.

## 2.2 INSTITUTIONAL DOMINATION IN SOCIAL CARE

### 2.2.1 THE NATURE OF 'TOTAL INSTITUTIONS'

Law and regulation have tried to tackle two interrelated concerns associated with institutions, identified by Townsend (1763) as:

- The manner of admitting persons into houses now kept for the reception of lunatics; and
- The treatment of them during their confinement.

It is important to recognise that what we mean by an 'institution' may be more complex than a type of building or organisation which is designated as such by a licensing and regulation authority. To a very significant degree, the way a person is treated within a particular space is what *characterises* it as an institution.

Goffman (1961: 17) described a 'family of attributes' which are often found in what he called 'total institutions', but none were 'peculiar to total institutions, and none seems to be shared by every one of them'.<sup>19</sup> Total institutions were likely to be a single physically and socially bounded space, and there was often a breakdown of barriers between different spheres of life such as work, sleep and socialising. There was usually a strongly stratified social hierarchy between 'staff' and 'inmate' groups, with heavily restricted social mobility and intercourse between those groups. Both groups enjoy differing and asymmetric rights to resources, spaces, activities and modes of communication; there is an asymmetry in the information they hold, and produce, about each other. 'Inmate' groups were often subject to surveillance by staff groups, and staff often operated systems of privileges and punishments.

These properties are found in a surprisingly broad range of environments. In addition to the large psychiatric hospital where he conducted his own ethnographic research, Goffman described prisons, army barracks, ships, submarines, boarding schools, monasteries, convents and universities with on-campus accommodation as having some similar properties. Other researchers have identified cruise liners (Tracy, 2000), Disneyland (Ritzer and Liska, 1997) and the situation of women living with abusive, controlling and violent partners (Avni, 1991) as displaying many of the properties of total institutions. Researchers writing in other traditions have described the way that 'Activities that form the routines of home' can 'become imbued with the institutional logics' when people receive home care services (Angus et al., 2005: 163; Luken and Vaughan, 1991).

Although many care services today aspire and claim to be non-institutional in character, there may be discrepancies between these claims and the degree to which they manifest these characteristics. At the heart of Goffman's analysis is a particular family of power relations between a body of staff and those whom the staff act upon. This means that understanding whether a person might experience their living arrangements as a 'total institution' requires us to look deeper than the philosophies and legal structures a form of accommodation claims to adhere to. It also means that to a

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<sup>19</sup> 'Total institutions' are thus what Wittgenstein (2001: [77], [164], [179]; 1958: 20, 33, 88) called a 'family resemblance' term, where a word or phrase denotes a set of overlapping features but where there is no single 'essence' which uniquely designates all members of that category.

certain extent Townsend's problematic is circular: whether or not a person is admitted to an 'institution' will depend on the practices in the place where they are living.

## 2.2.2 COMMUNITY CARE LAW AND POLICY FOR PEOPLE WITH LEARNING DISABILITIES IN THE 20<sup>TH</sup> AND 21<sup>ST</sup> CENTURIES

### FROM COLONIES AND CONTROL, TO CARE IN THE COMMUNITY

The first half of the 20<sup>th</sup> century saw legislation specifically directed towards the care and control of adults with learning disabilities, culminating in the Mental Deficiency Acts of 1913 and 1927. These Acts sought to move adults with learning disabilities out of the public asylums into newly established 'colonies', or to subject them to formal arrangements for their supervision and 'control' in the community (Fennell, 1992). A primary purpose of segregation in colonies and community-based control was preventing people with learning disabilities from procreating; a compromise arrived at after eugenicist proposals for mass sterilisations were met with opposition from an unlikely coalition of Catholics and civil libertarians (Fennell, 1992; Kevles, 1999; King and Hansen, 1999; Larson, 1991). The 1913 Act required local authorities to ascertain all the 'idiots', 'imbeciles', 'feeble-minded persons' or 'moral defectives' in their areas, and either accommodate them in an institution or else to place them under guardianship or some other form of supervision.

Fennell (1992) writes that guardianship was slow to take off, peaking in 1947 at only 4,798 people. He attributes this peak in the use of guardianship during the 1940's to a lack of institutional provision and no alternative means – prior to the National Assistance Act 1948 – for a local authority to provide payment for care arrangements. From the perspective of legalism, the significance of the National Assistance Act 1948 and later community care statutes<sup>20</sup> was the establishment of powers for local authorities to pay for accommodation of persons 'in need of care and attention which is not otherwise available to them' without the need for a formal admission under mental health legislation or entry into guardianship. It is not entirely clear whether or not people always consented to placement in that accommodation.

During the 20th century there was an increasing policy preference for 'care in the community', rather than care in the large healthcare facilities which evolved out of the old asylums. By the 1960's there was growing disdain for institutional forms of care, prompted by a wave of hospital scandals (Roberts, 1981b) and bolstered by the increasingly fashionable writings of Goffman, Foucault and others. However, for much of the century adequate community provision never materialised to replace the old long-

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<sup>20</sup> These will be discussed in more detail in Chapter 3.

stay hospitals and colonies, resulting in 'revolving door' admissions to mental hospitals (Means et al., 2008: 38). The NHS and Community Care Act 1990 placed local authorities under much stronger duties to assess a person's needs for care services.<sup>21</sup> The Act also enabled local authorities to commission care services to discharge their community care powers and duties from the independent sector, rather than having to provide them directly themselves.

By the year 2011-12, 93% of all local authority funded residential care for adults with learning disabilities was provided by voluntary and for-profit organisations, as was 89% of home care for all service users.<sup>22</sup> There are important policy debates about whether or not the 'privatisation' of community care services has led to a decline in quality and diversity (Drakeford, 2000; 2006; National Development Team for Inclusion, 2011). However, for the purposes of this thesis, the main significance of 'privatisation' of care services is that those providers may not be 'core' public authorities in the meaning of s6 Human Rights Act 1998 (HRA).

The HRA was deliberately designed to accommodate the increasing 'outsourcing' of public functions to the independent sector, in the form of 'functional' or 'hybrid' public authorities whose 'functions are of a public nature'.<sup>23</sup> However in a controversial ruling in *YL v Birmingham City Council*<sup>24</sup> the House of Lords concluded that in providing care services, even those arranged and funded by local authorities, private care providers did not exercise 'functions of a public nature' in the meaning of s6 HRA. This meant that residents of those services could not rely upon the s7 HRA mechanism to challenge decisions by care providers that violated their rights under the ECHR. Following an outcry over this ruling (JUSTICE et al., 2007; Robins, 2007)<sup>25</sup>, the government introduced legislation that made the provision of residential care services functions of a public nature in the meaning of s6 HRA, so long as they were arranged under the National Assistance Act 1948.<sup>26</sup> However, this amendment did not include domiciliary

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<sup>21</sup> S47 NHS and Community Care Act 1990

<sup>22</sup> These data were calculated using the following figures taken from supporting tables provided by NHS Information Centre for Health and Social Care (NHS Information Centre for Health and Social Care, 2012c): In 2011-12, local authorities in England arranged 1,698,040 weeks of residential care for adults with learning disabilities; of these only 113,980 were provided by in-house residential care services. In 2011-12 local authorities in England supplied 188,206,114 hours of home care to all service users, of these only 20,302,060 were provided through in-house domiciliary care services.

<sup>23</sup> s6(3)(b) HRA

<sup>24</sup> [2007] UKHL 27

<sup>25</sup> The judgment has also been the subject of extensive academic commentary, with many taking the view that the judgment was legally or morally flawed (Carr and Hunter, 2010; Hale, 2009a; McDermont, 2010; Palmer, Ellie, 2008a; Palmer, Stephanie, 2007; 2008b; Sanger, 2008; Williams, Alexander, 2008).

<sup>26</sup> s145 Health and Social Care Act 2008

care services or residential services arranged under other Acts.<sup>27</sup> There have been ongoing criticisms (Equality and Human Rights Commission, 2011a; Joint Committee on Human Rights, 2006; 2007a; 2008a;b; 2010) and repeated legislative efforts to rectify this state of affairs, but none have yet succeeded in parliament.<sup>28</sup> The MCA and the DoLS intersect with the HRA in several important respects, outlined more fully in Chapters 4-7. The lack of traction of the HRA in certain settings means that the potency of the MCA and the DoLS themselves may be diluted in services that are not public authorities in the meaning of s6 HRA.

## SOCIAL MODELS OF DISABILITY

During the latter half of the 20th century, policies towards people with learning disabilities began to shift away from abhorrent eugenics-inspired policies of 'control', towards policies which promoted equality and inclusion. These were heavily influenced by the various developing social models of disability, which are typically broken down into three important strands of thought (Dimopoulos, 2010):

1. Philosophies of 'normalisation' originating from Scandinavian countries, typically associated with the work of Wolfensberger (1972; 1980; 1983). The principle of 'Normalisation' promotes the acceptance of people with learning disabilities as equal citizens and ensuring they enjoy the same opportunities and patterns of life as non-disabled adults. There is a particular focus on de-institutionalisation in writings on Normalisation, and having a lifestyle broken down into periods of work, leisure and holidays modelled on the lifestyles of non-disabled citizens.
2. In North America during the 1970's a civil rights inspired 'minority group' approach to disability took shape. This focussed on 'the way in which disadvantaged people are portrayed or perceived by the public' (Dimopoulos, 2010). These approaches emphasised the importance of social inclusion rather

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<sup>27</sup> For example, it is unclear that residential care arranged under s117 MHA after-care arrangements would be covered by this amendment.

<sup>28</sup> In the parliamentary session 2005-2006, Paul Burstow MP introduced a bill (Care of Older and Incapacitated People (Human Rights) Bill) which would have made all care homes public authorities in the meaning of s6 HRA, regardless of whether care was privately or publicly funded and arranged. In the session 2008-2008, former JCHR chair Andrew Dismore MP introduced a bill (Human Rights Act 1998 (Meaning of Public Function) Bill) which would have listed 'the extent to which the state, directly or indirectly, regulates, supervises or inspects the performance of the function in question', 'the nature and extent of any statutory power or duty in relation to the function in question' and 'the extent to which the state makes payment for the function in question' as specific factors to be considered by the courts when determining whether or not an activity was a function of a public nature under s6 HRA. In the parliamentary session 2011-2012 Baroness Greengross and Lord Rix introduced an amendment to the Health and Social Care Act 2012 (amendment 217A) which would have made all domiciliary care services public authorities within the meaning of s6 HRA, regardless of whether or not the care was publicly or privately funded or arranged. All three bills and amendments failed to gain parliamentary support.

than segregative policies which allowed the conditions of people with disabilities to be ignored by society.

3. In Britain, the newly formed Union of the Physically Impaired Against Segregation (1976) declared, as a fundamental principle, that disability was not a medical condition located in an individual but 'a situation, caused by social conditions'. They called for the elimination of the social and attitudinal barriers that contributed towards disabling situations, and emphasised the importance of giving disabled people control over their own lives. This evolved into what is now often called the 'British Social Model of Disability', with a well known elaboration by Mike Oliver (1990a; Oliver, 1990b).

All three social models have proved enormously influential over the past decades, and traces of their distinct approaches can be seen in the UN CRPD. Normalisation, in particular, has been described as an 'evangelical' movement 'with associated doctrinal squabbles and schisms' (Brown, H and Smith, 1992). It is something of an 'orthodoxy' for social care professionals working with people with learning disabilities (Deeley, 2002), although its principles are not always supported so enthusiastically by family carers (Heyman and Huckle, 1993; Jingree, Treena and Finlay, 2011). Normalisation has also been extremely influential for the government's flagship policy for people with learning disabilities, *Valuing People* (Department of Health, 2001; 2010e)<sup>29</sup>, which promotes rights, choices, independence and inclusion. As will be seen in later chapters, this can sometimes lead to tensions between families and professionals, where families would prefer to care for relatives with learning disabilities in their own homes. A related issue is the extent to which 'normalisation' can be coercively imposed upon a person; Wolfensberger (1980) at least appeared to believe that 'Normalizing measures can be offered in some circumstances, and imposed in others.'

Whilst the social models of disability have undoubtedly been extremely important in political activism relating to disability, these models are not without their critics. One common theme is that they have been too strongly oriented towards the needs of people with physical disabilities, and not sufficiently attuned towards adults with learning disabilities (Dimopoulos, 2010). Philosophies of normalisation have been criticised as theoretically weak, reflecting the concerns of professionals not people with learning disabilities, and insufficiently insensitive to relations of power (Chappell, 1992). Normalisation philosophies have also been critiqued for the assumption that being 'different' was problematic, and that disabled people should conform to the norms of the non-disabled population (Morris, J. 1991).

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<sup>29</sup> For a discussion of the influences on *Valuing People* see Burton and Kagan (2006).



Shakespeare (2006) has written a careful and detailed critique of the British Social Model, emphasising that whilst many ‘disabling’ aspects of a person’s situation can be located in their social conditions, not all can. Some aspects of disability arise from complex interactions between a person’s impairment and their environment, and some functional limitations or aspects of disabled people’s experiences may not be eradicable by environmental and social changes at all. Shakespeare’s critique has met with resistance and controversy in some quarters (Koch, 2008), however some of those closely associated with the British Social Model have recognised many aspects of it as valid (Sheldon et al., 2007). Although Shakespeare’s criticisms of the social model will not be taken up in any great detail in this thesis, his concerns potentially have important implications for approaches to Article 12 CRPD. It has been suggested that the CRPD as a whole, and Article 12 in particular, was drafted on the basis of a populist conception of the social model of disability which did not acknowledge important issues raised in contemporary critical disability studies (Kayess & French, 2008: 7, 33-4). This is one reason why this thesis has not, as some associated with Article 12 CRPD seem to be suggesting, advanced the argument that it is feasible to abolish *all* interferences with a person’s choices and freedoms that are currently legitimated under the MCA.<sup>30</sup>

#### THE ‘PERSONALISATION’ OF CARE SERVICES

In response to lobbying by disabled people’s organisations, ‘direct payments’ were introduced/<sup>31</sup> to enable disabled people to purchase care services directly themselves, instead of relying on services provided or commissioned by public authorities. This approach is often called ‘self-directed support’ (SDS). Meanwhile, health and social care practitioners began to develop ‘person-centred’ philosophies of care (Bowers et al., 2007; Brooker, 2007; Kitwood, 1997; Sanderson, 2011). Person-centred philosophies of care emphasise the importance of planning support around a person’s own needs and preferences, and not subordinating them to the interests of care services. Person-centred philosophies of care have been criticised for being vague, under theorised and the term can sometimes be indiscriminately used ‘for practices that serve service providers’ rather than patients’ interests’ (Entwistle, 2012). For example, a service inspected by the CQC described itself as person-centred, yet CQC later found that staff were imposing strict rules and regimes, and a system of punishments and rewards upon residents (Care Quality Commission, 2010e; 2011d).

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<sup>30</sup> Although neither do I suggest that if some such interferences continue to be permissible, a structure like the MCA should be used to legitimate and regulate them.

<sup>31</sup> Community Care (Direct Payments) Act 1996; now superseded by ss57-8 Health and Social Care Act 2008

Both person-centred and self-directed philosophies of care have had a considerable influence over official policies of 'personalisation' of care services over the last decade (Department of Health, 2005d; 2006c; 2007a; Department of Health and Others, 2007; Department of Health, 2010c; 2011d; 2010b) and regulatory standards (Care Quality Commission, 2010c). Person centred philosophies of care are certainly more desirable than service-centred care, but they are not necessarily incompatible with staff exercising considerable control over a person in their 'best interests'.

## SUPPORTED LIVING

During the 1990's community care services were developed further towards providing people with learning disabilities with the opportunity to live in their own home with support, rather than living in 'institutional' residential care services. The 'Reach Standards' (Gitsham et al., 2001) are generally regarded as paradigmatic of what supported living services aspire to, and are as follows:

- I choose who I live with
- I choose where I live
- I have my own home
- I choose how I am supported
- I choose who supports me
- I get good support
- I choose my friends and relationships
- I choose how to be healthy and safe
- I choose how to take part in my community
- I have the same rights and responsibilities as other citizens
- I get help to make changes in my life

The standards are clearly imbued with the principles of equality and inclusion which animate all social models of disability. Although the Reach Standards are not legally enforceable they are frequently cited in policy and even regulatory literature (e.g. Commission for Social Care Inspection and Healthcare Commission, 2006; Fyson et al., 2007; Wood et al., 2010; Wood and Greig, 2010). Supported living services are also a central plank of the housing and support options local authorities are expected to provide under *Valuing People* (Department of Health, 2001: 3, 72-73). Additional streams of funding are available for supported living services for adults with learning disabilities in

comparison to residential care services.<sup>32</sup> However, many of these streams of funding are drying up or being used for other purposes in the face of growing cuts to central and local authority budgets.<sup>33</sup>

In regulatory terms, supported living services are domiciliary care provided to a person in their own home, in contrast with residential care homes.<sup>34</sup> The legal distinction between a 'care home' and supported living is complex, and has resulted in litigation where it was found that a domiciliary care agency and landlord were working in concert as a single 'establishment', thus bringing them within the regulatory structure of a care home and not domiciliary care.<sup>35</sup> The status of a service as domiciliary care or a care home alters the landscape of interpretation and enforcement of the MCA in several respects. In the first place, domiciliary care services are less likely to be public authorities in the meaning of the HRA.<sup>36</sup> However, service users should, technically

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<sup>32</sup> These included the Learning Disability Development Fund, the Independent Living Fund and money from the Supporting People program.

<sup>33</sup> The Learning Disability Development Fund and Supporting People funding is not ringfenced, and there is evidence that council's increasingly spend non-ringfenced funds for social care on non-social care activities (Dunning, 2011b; a). The Independent Living Fund provided additional funding to support disability-related costs for people living in their own homes, in recognition that some people's support needs incurred especially high costs. The Fund closed to new applicants in 2010, and the government are consulting on its closure to existing applicants and redistributing the funds to local authorities without any ringfence (Department for Work and Pensions, 2012; Gheera, 2012).

<sup>34</sup> Under s3 Care Standards Act 2000 'an establishment is a care home if it provides accommodation, *together with* nursing or personal care' (emphasis added), and was distinct from domiciliary care where accommodation was provided by a separate entity to the care provider. The Health and Social Care Act 2008 replaced the regulatory regime of the Care Standards Act 2000, but did not repeal the Care Standards Act altogether. The term 'care home' is not found in the Health and Social Care Act 2008, although the registration requirements for services which provide 'residential accommodation, together with nursing or personal care' are distinct from those which just provide home care (r2 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 SI 2010/781). The Care Standards Act 2000 distinction between a care home and domiciliary care has been formally retained for the deprivation of liberty safeguards (s17 The Health and Social Care Act 2008 (Consequential Amendments No.2) Order 2010 SI 2010/813). Throughout this thesis, I will use the term 'care home' to refer to accommodation provided 'together with' support, and domiciliary care to refer to care which is provided in a property which, at law, is regarded as a person's own home.

<sup>35</sup> In *Alternative Futures* the Court of Appeal found that services which had sought to re-register from care homes to a separate landlord and domiciliary care agency could still be a single 'establishment', despite being two separate organisations. The tribunal hearing looked at a large range of possible reasons why the two organisations should be considered a single establishment, including doubts over the validity of a tenancy of a person who lacked capacity to contract, and whether or not they had exclusive possession of their property and could exclude care staff. However, the Court of Appeal merely confirmed that the two organisations could be a single establishment, but gave no guidance as to what factors should be taken into consideration and did not endorse the lower court's reasons for coming to this conclusion. *Alternative Futures Ltd v National Care Standards Commission* [2002] EWCST 111(NC); *R (Moore) v Care Standards Tribunal* [2004] EWHC 2481 (Admin); *R (Moore) v Care Standards Tribunal* [2005] EWCA Civ 627. See also recent guidance issued by CQC (2011g: 2) on the distinction between care homes and supported living, and discussion paper by Voluntary Organisations Disability Group and Anthony Collins Solicitors (2011).

<sup>36</sup> Because of the ruling in *YL v Birmingham City Council*, see earlier discussion.

speaking, enjoy rights as tenants that care home residents would not. Difficulties have arisen around the legal status of tenancies for people in supported living services who are considered to lack the mental capacity to enter into them.<sup>37</sup> Although such services must be registered with the CQC,<sup>38</sup> the regulator is prohibited from using their powers of entry and inspection for premises 'used wholly or mainly as a private dwelling'.<sup>39</sup> This means that, in contrast with hospitals and care homes, supported living services are not subject to any site inspections or visitation by the CQC. The Equality and Human Rights Commission (EHRC) and Cynthia Bower, former chief executive of the CQC, have described 'non-institutional' care, which is delivered 'behind closed doors' in people's own homes, as inherently more difficult to regulate (Equality and Human Rights Commission, 2011a: 88; Joint Committee on Human Rights, 2011: 49).

Although supported living services are closely linked to de-institutionalisation programs, and should - technically speaking - afford people considerable rights as tenants or owners of their properties, they have not always lived up to the aspirations embodied by the Reach Standards. Kinsella (2008) was heavily involved in developing supported living services, but has complained that its principles have too often been crudely translated into 'give people a tenancy, deregister and get Supporting People funding in'. He comments that 'Too much of what goes today as Supported Living is relabelled Residential Care.' Fyson, Tarleton and War (2007) found that supported living services often manifested institutional practices more closely associated with residential care than the Reach Standards. For example, staff did not always appreciate the significance of working in a person's own home: some held keys to the property, designated particular rooms as 'their' offices, and imposed rules and restrictions on residents in these services. In response to safeguarding alerts about their own supported living services, Family Mosaic (2012: 9) described 'alarming evidence to show that the practices and attitudes generally associated with institutionalisation that were embedded in the old long-stay institutions, have not disappeared with the advent of community care'. They concluded 'The reality is institutionalisation and the processes associated with it don't only occur in residential settings.' Duffy (2012: 7) has expressed similar views, commenting that 'we'd knocked down the walls - we'd moved people into the community - but we'd taken the institution with us'.

In 2006 the Commission for Social Care Inspection (CSCI) and the Healthcare Commission (2006) reported finding serious abuse of around one hundred adults with learning disabilities in Cornish supported living services. The abuses found in these

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<sup>37</sup> See, in particular, the rulings of the Upper Tribunal in *Wycharon District Council v EM* [2011] UKUT 144 (AAC) and *Wycharon District Council v EM* (HB) [2012] UKUT 12 (AAC).

<sup>38</sup> The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 SI 2010/781

<sup>39</sup> s62(4) Health and Social Care Act 2008

services mirrored the kind of institutional abuse scandals in healthcare services such as Winterbourne View hospital in Bristol – the subject of a recent scandal revealed by undercover reporters for BBC Panorama (Flynn, 2012; Kenyon, 2011). The police report linked the abuse in Cornish supported living services to the lack of any regulatory scrutiny of those services (FOIA #2). The Mental Health Act Commission ('MHAC', 2008b: [3.33]) described it as 'a serious matter of concern that any learning disability unit that does not detain patients under the Act may still be relatively free of regular external visitation with the focus and methodology that the MHAC applies to its visits to detained patients.' These settings have been developed around the ideals of home, which is clearly laudable. But there is a reluctance to legislate or regulate for 'home' environments and 'private' life, and that makes power relations in these settings much harder to scrutinise or hold in check.

#### INSTITUTIONS, LAW AND THE 'TUTELARY RELATIONSHIP'

There is a tendency to associate care in the community and 'personalisation' with a shift towards decarceration and deinstitutionalisation. However, Fennell (1996) emphasises that 'what is described as community care may in fact be care in an institution, albeit smaller and not designated as a hospital'. Unsworth (1991) observed that in this 'post-carceral' era in the socio-legal history of mental disorder, the bond between the 'tutelary relationship' and the institution began to dissolve, and these relations of control were de-legalised as the fashion for informalism took hold. I suggest a slight adaptation of Unsworth's argument. That 'the institution' tends to follow the tutelary relationship, and they can be extremely difficult to break apart. What has been decoupled over the last fifty years is not the tutelary relationship from the institution, but the tutelary relationship *and the institution* from any source of formal legal authority, and associated legal and regulatory controls.

### 2.2.3 THE CHARACTERISTICS OF TWENTY-FIRST CENTURY INSTITUTIONS

A review of the research and grey literature reveals various clusters of concern around 'institutional' practices across a variety of health and social care settings where adults with learning disabilities often live.

#### INVOLUNTARY PLACEMENT

Most people choose where they live and who they live with, within varying constraints, but people with learning disabilities are often 'placed' in a service. Various concerns have been raised about the nature of these placements. Following widespread

public outcry after the abuse at Winterbourne View, there has been a growing focus on 'out of sight, out of mind' placements of people with learning disabilities in assessment and treatment centres. There is a general consensus that community placements are more appropriate, and that long-term use of healthcare settings should be phased out (Department of Health, 2012b; d; Mencap and Challenging Behaviour Foundation, 2012a; National Development Team for Inclusion, 2011; Rob Greig and other signatories, 2011). Research has also demonstrated that grouping together people with learning disabilities and 'challenging behaviour' is associated with detrimental outcomes for residents and the quality of staff interactions (Mansell and Beadle-Brown, 2004). A significant proportion of 'safeguarding alerts' about adults with learning disabilities give the alleged perpetrator as 'other vulnerable adult'; these may well be other residents in group homes (NHS Information Centre for Health and Social Care, 2011a; Series, 2011a).

Concerns have also been raised about adults with learning disabilities being placed at long distances from their families and home communities (Edwards et al., 2012; Mansell, 2007; Mencap and Challenging Behaviour Foundation, 2012b; Rob Greig and other signatories, 2011). As many as 30% of adults with learning disabilities are estimated to be placed 'out of area' (Mansell, 2007), rising to 60% for people from the London area (Whelton, 2009). The EHRC (2010) has expressed concern about the lack of scrutiny of people living in these placements. The Royal College of Psychiatrists has described people placed far from their families and home communities as amongst the most socially excluded people in the UK (Edwards et al., 2012). The Department of Health (2012d: [3.11]) has acknowledged that out of area placements can 'cause real harm to individuals by weakening relationships with family and friends and taking them away from familiar places and community', 'damage continuity of care', that they mean 'putting people into settings which they find stressful or frightening' and they 'damage mental health or increase the likelihood of challenging behaviour'. The Department has reiterated that out of area placements should only occur where there are 'clear and compelling reasons' and has committed to monitoring them, but has not legislated for any restrictions on their use.

Placement in care services can sometimes give rise to tensions between families and professionals. Several researchers have described how parent carers in particular often want their sons and daughters to remain living at home with them, rather than moving out into residential care or 'supported living' accommodation (Bowey and McGlaughlin, 2005a; Bowey and McGlaughlin, 2005b; 2007; Jingree, Treena and Finlay, 2011; Williams, V. and Robinson, 2001). Oulton (2009) has suggested that family carers exhibit a general mistrust of the abilities of others to care for their relatives. This may be

because family carers can be more risk averse than health and social care professionals (Heyman and Huckle, 1993; Heyman et al., 1997; Heyman, 1995; Oulton and Heyman, 2009). However, it also seems reasonable to suggest that family carers are more sceptical about the opportunities, and more sensitive to the risks of abuse in formal care services, than the professionals who tend to commission such services. It is known that a slightly higher proportion 'safeguarding' alerts concerning vulnerable adults relate to paid care workers, not relatives (NHS Information Centre for Health and Social Care, 2012b).

## INSTITUTIONAL RULES AND REGIMES

Rules and regimes are a key defining characteristic of institutional life. They are central to the 'mortifying' aspects of institutions (Goffman, 1961), which contribute towards depression and decline in wellbeing (Boyle, 2005; Langer and Rodin, 1976). This is an area of concern across all kinds of services catering for people with learning disabilities.

In national studies, regulators have reported concerns about the imposition of 'institutional' rules and regimes on people with learning disabilities in healthcare settings (Care Quality Commission, 2009a; 2012b; f; Healthcare Commission, 2007b). These restrictions and regimes manifested in all aspects of people's lives. For example, they included 'rigid routines with meals, drinks and snacks only being available at set times, and people being expected to be in their bedrooms at certain times of the day', 'written rules... that people were not allowed to converse over the fence with people in the service next door', and staff speaking to residents in a 'direct and authoritarian' manner (Care Quality Commission, 2012b: 29).

Earlier national audits by the Healthcare Commission and CQC only considered these practices in healthcare settings, which are only used by a tiny minority of people with learning disabilities. The most recent national audit, however, also incorporated residential care settings (Care Quality Commission, 2012b). Similar restrictions were found in residential care to healthcare settings, including restrictions on 'access to various communal rooms, kitchens, the person's own bedroom (whether locking people out of their bedrooms during the day, or insisting on a general and often early bedtime), and to the gardens or outdoor space' and 'about when a patient or resident might have a drink or a snack, or go for a cigarette'. These rules and restrictions were found to contribute towards considerable stress amongst residents (Care Quality Commission, 2012f).

No national audit of supported living services has ever been conducted, despite the Cornwall care scandal; this is most likely to be because the regulator has no powers

of entry or inspection for these services. However, Fyson, Tarleton and War (2007) found rules and restrictions being imposed by staff in supported living services. The following extract is from Family Mosaic's (2012: 15-16) report on 'institutional' characteristics which they found springing up in a minority of their own supported living services:

...staff were working in an institutional way... [T]here were strict routines in place denying people any choice or control. This included set times for getting up, eating and going to bed. In one scheme a customer's so-called challenging behaviour was managed by telling them where they had to stand in a room. In another scheme, a customer who kept taking her clothes off had them put on back-to-front to stop her undressing. Finally in a third scheme, access to toilets and kitchens were being controlled by staff... In another scheme the staff team would talk over the customers, gossip was rife and staff had an obsession with housework. So while the home was immaculate, the customers were ignored. Some of the cases were clearly abuse and staff were immediately suspended and dismissed.

Concerns about institutional practices can occur in any kind of setting, although the limited available evidence suggests they may be less common in supported living.

There is an increasing policy drive towards ensuring adults with learning disabilities enjoy more 'choice and control' over their lives. However, research suggests that their enjoyment of choice is tightly bounded by those choices that are acceptable to providers and commissioners of care services. For example, Hollomotz (2012: 1) writes that 'a person may be free to choose activities at their day centre, but they may have limited control when deciding whether to attend the service in the first place' and describes the 'mundane choices' available to people as 'tokenistic'. Using conversation analysis (Sacks, 1992), Antaki et al (2008) have found that whilst staff often appear to be giving choices, they often lacked the communication skills to do this in a meaningful way. Some choices, for example offering people an opportunity to use the bathroom, could reflect institutional imperatives and be actively disempowering (Finlay et al., 2008b). Finlay et al (2008b: 358) note that staff 'are answerable to other agendas which often conflict with the choice agenda' and conclude that because staff will always have an interactional advantage through their knowledge and verbal fluency, 'Disempowerment is woven into the fabric of social care'. Some have argued that 'empowerment' within care services is an illusion, because power is always 'on loan' by staff (Dowson, 1997; Jingree, Treena and Finlay, 2008). This connects with republican concerns that the withdrawal of choice and control is ever-present, may be arbitrary and at the discretion of institutional authorities.



## CHOICE AND CONTROL OVER WHO PROVIDES CARE, AND HOW

Carework is highly relational; care workers are not 'fungible' entities and care work cannot be reduced to task completion (Aronson and Neysmith, 1996; Clement, 1996; Dunn et al., 2008; Ellis, 2004; Fyson and Cromby, 2012; Herring and Foster, 2012; Morris, A., 2010; Stefan, 1992-1993). Unsurprisingly, therefore, a core concern of the disabled people's movement has been a person's ability to choose who supports them, and on what terms. Control over how one is supported, and by whom, is a central plank of the independent living movement and direct payments are a preferred means of achieving this (Jolly, 2009; Morris, J., 2004; Shakespeare, 2000). The rights to choose 'how I am supported' and 'who supports me' are built into the Reach Standards, and are central to government policies of personalisation (Department of Health, 2005d; 2006c). Empirical studies show broadly positive experiences of personal assistance (Spandler, 2004).

Models of personal assistance invert the power relations implicit in institutional care: a person may choose their own staff, set the goals the staff support them to work towards, choose who supports them with which tasks, and decide where and how they are supported in them (Ratzka, 2004). Direct payments have been found to shift power relations between service users and care staff away from traditional service provision models (Leece, 2010). Concerns about oppression and exploitation in personal assistance are typically centred on how *staff* are treated, rather than service users, as staff often experience limited job security, low wages and long working hours (Shakespeare, 2000).

The majority of people with learning disabilities use traditional residential care or domiciliary care services, although around 24,000 are in receipt of direct payments (NHS Information Centre for Health and Social Care, 2012h). When people live in residential care it may be extremely difficult for them to influence staff recruitment, rotas, and who supports them for particular tasks. Even in supported living services, Fyson, Tarleton and War (2007: 38) commented that 'We did not come across any examples of services in which the decision about who to receive support from was an entirely free choice for tenants'. There are no clearly established regulatory or legal standards that entitle a person to request that a particular care workers does, or does not, support them in a particular task – or at all. This may be problematic where a caregiving relationship breaks down, or was never established, or where people have particular preferences for care and support from a person of a particular gender, age, or cultural background.

## RESTRAINT, SECLUSION AND SEDATION

Restraint and seclusion represent extreme, physical, forms of control exercised over people with learning disabilities; unhappily neither is especially rare in services for people with learning disabilities. Restraint is defined by s6 MCA as the use, or threat of use, of force 'to secure the doing of an act which P resists' or restricting 'P's liberty of movement, whether or not P resists'. 'Mechanical restraint' is a term sometimes used to describe forms of restraint which employ environmental features or equipment, such as tethering a person to an environmental feature or their wheelchair, or use of rails to keep them in bed. Seclusion is not defined by the MCA, but the MHA code of practice defines it as 'confinement of a patient in a room, which may be locked', and cautions against using euphemistic language to mask its use (Department of Health, 2008a: [15.43]). 'Sedation' is the use of psychoactive medications which have the effect of sedating or tranquilising a person; this is also sometimes termed 'chemical restraint' (Commission for Social Care Inspection, 2007: 8). Sedating medications are sometimes administered *pro re nata* (PRN), which means 'as and when required', by care staff – giving them substantial control over a person's mood and mental state.

Restraint is reported to be used in roughly 50% of services for people with learning disabilities (Deveau and McGill, 2009; Sturmey, 2009b). Concerns about its unnecessary, excessive and inappropriate use are repeatedly raised in national studies of services for people with learning disabilities (Care Quality Commission, 2009a; Healthcare Commission, 2007b), and its potential for misuse and overuse is a live policy issue (Stubbs et al., 2009; Sturmey, 2009a). In its most recent audit of learning disabilities services, the CQC (2012b) found that only 71% of residential care services, 61% of assessment and treatment centres and 54% of secure units were compliant with regulatory standards for restraint (Emerson, 2012: 9). Restraint is sometimes used by staff with little or no training (Deveau and McGill, 2009; Matson and Boisjoli, 2009; Murphy et al., 2003). Studies on the frequency of the use of restraint suggest it is not employed as a measure of last resort (McGill et al., 2009). In a rather exotic demonstration that the need for restraint can be highly contingent upon the mental state of staff and not necessarily those it is practised upon, studies found that teaching staff 'mindfulness meditation' could reduce its use (Singh et al., 2009).

Restraint can cause physical injury, and even death (Murphy et al., 2003; Parkes et al., 2011; Weiss, 1998; Williams, D., 2009). In their national audit of healthcare services the Healthcare Commission (2007b) reported that 10% of services for people with learning disabilities used 'mechanical restraint'. The MHAC have previously expressed concern that forms of 'mechanical restraint' which are explicitly prohibited by

the MHA code of practice (Department of Health, 2008a: [15.31]), including tying people to features of their environment, are still practised in the care of older people and people with learning disabilities (Mental Health Act Commission, 2005; 2008b; 2009b). The use of seclusion has also been a source of concern in regulatory reports on both healthcare and residential care services for people with learning disabilities. However, it was not always recognised as such, and appropriate safeguards and checks are not always implemented (Care Quality Commission, 2012b; f; g).

There are serious concerns about the use of sedating anti-psychotic medications in social care. In a study of their use on dementia patients, Banerjee (2009) found they brought no benefit to the patient in 80% of cases, they carried serious risks to health and wellbeing, and their use was linked to a lack of skills for non-pharmacological support for behavioural disorders in dementia. Harding and Peel (2013) have described the 'overwhelmingly' negative effects of these medications on people with dementia from the perspective of carers. It is estimated that 80% of healthcare services for people with learning disabilities use PRN medications to manage behaviour (Healthcare Commission, 2007b; Sturmey, 2009b). There are no official estimates for their use in residential care or supported living settings, but studies have found that use of sedating antipsychotic medications 'increases dramatically' among older people upon entry into residential care services (Maguire et al, 2013). The Healthcare Commission (2007b) recommended that services focus on using alternative methods to manage behaviour, rather than relying on medication. CQC (2009a: 24) has expressed concern that PRN medication was being used 'as a form of restraint', but this issue does not appear to have been considered in their most recent audit of learning disabilities services (Care Quality Commission, 2012b).

## PRIVACY

A loss of 'privacy' may be understood as exposure of certain intimate details of our lives to the surveillance or control of others. In care settings, concerns around 'privacy' often revolve around bodily integrity, enjoyment of private spaces, private enjoyment of one's possession and enjoyment of relationships with others without intrusion or interference by staff. Clearly these concerns overlap with several other areas discussed here.

Twigg (1999; 2000b; a; 2004) has described carework as a form of bodywork, and Lanoix(2009) has described 'how a person's relationship to her own body can be undone to the point where she might feel it is no longer her body' as a result of institutionalized practices by caregivers. Institution survivor Amanda Baggs (2012a) has written that:

Disabled people are far more likely than others to have others behave invasively with us, ranging from subtle to violent. People teach us from our earliest years onward that such invasion is normal, natural, and something we should accept without complaint. We have to have the means to say no.

Goffman identified the surveillance of service users by staff as a key characteristic of total institutions, and it is often described in reports and descriptions of modern institutional life. In the extreme example of the abuse in Cornish supported living services, it was found that providers had installed CCTV in people's own homes to enable them to monitor a wider area with fewer staff (Commission for Social Care Inspection and Healthcare Commission, 2006). Vincent (2010: 47) voluntarily admitted herself to various psychiatric institutions in the USA to write a journalistic book about her experiences, and wrote that being watched is 'a soft violation that grows into a harder one with every passing day'.

Consideration of private spaces appears frequently in CQC reports, often around whether or not care staff knock on peoples' bedroom doors before entry,<sup>40</sup> or repeated exhortations to provide lockable spaces for possessions (Care Quality Commission, 2011e; 2012f). Several writers in the 'geographies of care' tradition have described how staff come to exercise control over spaces and resources through institutionalised practices (Conradson, 2003; Dovey, 2005; Liaschenko, 1994; Milligan, 2010; Wiles, 2003). Hollomotz (2009) has described how some people with learning disabilities in group homes are not allowed to spend time in private with their partner, driving their sexual activity into isolated public or semi-private spaces.

The recording and sharing of intimate information about service users is a common feature of 'formal' care settings, in part perpetuated by regulatory and legal demands. In their report on institutional practices, Family Mosaic (2012: 30) comment that 'Life may become - or feel - altogether more public, with staff discussing matters related to a person's wishes or care needs in front of others.'

#### INSTITUTIONAL CONTROL OVER RELATIONSHIPS WITH FRIENDS AND FAMILY

Institutional life can make it extremely difficult to forge, or maintain, relationships with people outside of the institution. As discussed earlier, out of area placements can be extremely damaging to relationships between people with learning disabilities and their families. Where people are moved between services, or are unable to enjoy meaningful access to the community, it can be difficult to develop or maintain friendships. In their national audit of healthcare settings, the Healthcare Commission

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<sup>40</sup> See study B2 in Appendix B.

(2007b) found that half of people in those services had never received a visit from friends or family, and only 11% had received a visit in the last month. Difficulties may be exacerbated by institutional controls imposed over modes of communication. The CQC (2012f: 19) found healthcare and residential care services for people with learning disabilities imposing 'blanket rules' on the use of mobile phones, restrictions on the length of time spent on the telephone, or bans on the use of computers or the internet. Sometimes service-provided telephones did not work or could not be used in privacy. The MHA code of practice calls for hospitals to 'make every effort to support the patient in making and maintaining contact with family and friends by telephone and to enable such calls to be made with appropriate privacy' (Department of Health, 2008a: [16.3]). However, the CQC (2010f: 47) has encountered blanket bans on the use of mobile phones for people detained under the MHA.

One sad but striking finding of the Healthcare Commission (2007b) was that 'Very few people had friendships apart from those with paid staff' (p35). Friendships can be a valuable and enriching part of everybody's lives; people with learning disabilities are no different (Chappell, 1994; Knox and Hickson, 2001). However, adults with learning disabilities often have difficulties forming friendships (Chappell, 1994) and report that this as an area of concern to them (McVilly et al., 2006). Poverty, transport difficulties and the absence of emotional and practical support can hinder the development of friendships and contribute towards loneliness (Nunkoosing and John, 1997; Whitehouse et al., 2001). Too often 'community integration' – an oft-espoused ideal for people with learning disabilities – is understood as 'activities', not relationships with individuals in the community (Myers et al., 1998). The feelings of social isolation experienced by people with learning disabilities increases feelings of a lack of self-worth, and can contribute towards behaviour regarded as 'challenging' or 'problematic' by others (Heyman et al., 1997). Talk of helping people with learning disabilities develop and maintain friendships with people outside of the institution, however, appears only rarely in official policy and regulatory literature.

## ABUSE

Abuse is defined in *No Secrets*, the government's official policy on 'safeguarding vulnerable adults', as 'a violation of an individual's human and civil rights by any other person or persons' (Department of Health and Home Office, 2000: [2.5]). Clearly, therefore, many issues in the foregoing discussion will constitute forms of abuse. *No Secrets* describes several categories of abuse. 'Physical abuse' includes 'hitting, slapping, pushing, kicking, misuse of medication, restraint, or inappropriate sanctions'. 'Sexual abuse' includes rape and other non-consensual sexual acts. 'Psychological

abuse' includes emotional abuse, threats of harm or abandonment, humiliation, harassment and isolation. Also described are 'financial or material abuse', 'neglect and acts of omission' and 'discriminatory abuse'. A breakdown of official statistics on 'safeguarding' referrals for 'vulnerable adults' (NHS Information Centre for Health and Social Care, 2011b) reveals that safeguarding alerts for people with learning disabilities are most likely to relate to physical abuse, then neglect, financial abuse, psychological, emotional/psychological and then sexual abuse. People with learning disabilities are the group with the highest number of safeguarding alerts relating to sexual abuse (Series, 2011a).

All these forms of abuse have been found across all kinds of care services for people with learning disabilities. Each decade, it seems, is rocked by one or more major abuse scandal, from Ely Hospital in the 1960's (Report of the Committee of Inquiry into Allegations of Ill – Treatment of Patients and other irregularities at the Ely Hospital, 1969), Longcare's residential care services in the 1990's (Buckinghamshire County Council, 1998), Cornish healthcare and supported living services in the mid 2000s (Commission for Social Care Inspection and Healthcare Commission, 2006) to the most recent in this succession of scandals – the abuse of adults with learning disabilities at Winterbourne View hospital in Bristol (Flynn, 2012; Kenyon, 2011). Each of those scandals reported staff hitting, slapping, pushing and kicking residents, and inappropriate use of restraint and seclusion. Many of them found strong evidence of sexual abuse – although successful prosecutions rarely followed because of prosecutorial concerns about the reliability of witness testimony by victims with learning disabilities (FOIA #2). Several involved financial abuse, and all involved emotional abuse, neglect and discriminatory abuse.

Whilst these cases certainly give cause for concern, those issues which are often recognised by safeguarding bodies and the public as a form of abuse represent only an extreme end of a broader spectrum of systematic exclusion, discrimination and human rights violations of people with learning disabilities. Sexual assault, hitting, slapping and name calling tends to catch the public eye, whilst placements far from home, bans on using the telephone, early bedtimes and limits on the number of cigarettes smoked or snacks consumed tend not to. Yet all often represent unnecessary and inappropriate interferences with the rights of people with learning disabilities, which would be unlikely to be tolerated by the general population. Concerns in the policy and grey literature about involuntary placement, the imposition of rules and regimes, practices which impinge upon privacy, and the use of sedation, seclusion and restraint, reflect a belief that these practices do not conform to any principles which are, or should be, accepted as 'good practice'. These are not critiques of interferences *per se* which people with

learning disabilities might be subject to in care services, they are critiques of their excesses, their arbitrariness and their unprincipled nature. That is to say, these are concerns of a republican nature.

## 2.3 THE PROBLEM OF DOMINATION AND THE NEW REPUBLICANISM

To recap, philosophers writing in the new republican tradition hold that a person is 'dominated' to the extent that they are subject to arbitrary interferences with their choices and freedoms. Republican liberty is distinct from what Isaiah Berlin (1958) termed 'negative liberty' – freedom from the interferences of others. Negative liberty can be discerned in many traditional liberal writings, including works by J.S. Mill (1859/2005), Bentham (1843) and even the jurist Sir William Blackstone (1765-1769). By contrast, republicans hold that interferences do not deplete liberty, so long as those interferences are non-arbitrary. Furthermore, republicans hold that a person can be dominated even if they were only subject to *potential*, and not *actual*, interferences. Pettit (1993; 1995; 1997a; b; 2002; 2003; 2007; 2008b; a; 2009; 2012) has written extensively on the subject of republican liberty, and he derived inspiration from writings on liberty found in classical antiquity (Skinner, 1997). These writings cast liberty in opposition with being a slave, where a person was subordinated to the will of another. Importantly, a slave could enjoy an existence relatively free of actual interferences, through tactics of obedience and deference. Lovett (2010b) writes that 'political liberty might better be understood as a sort of structural relationship that exists between persons or groups, rather than as a contingent outcome of that structure'.

Examples of domination found elsewhere in the republican literature include (Pettit, 1997b: 57):

...the husband who can beat his wife for disobeying his instructions and be subject, at most, to the mild censure of his neighbours; the employer who can fire his employees as whim inclines him and hardly suffer embarrassment for doing so; the teacher who can chastise her pupils on the slightest excuse or pretence at excuse; the prison warder who can make life hell for inmates, and not worry much about covering her tracks...

To these examples we might add: those working in the caring professions insofar as they exercise arbitrary power over care service users. Because republican liberty is concerned with a structural relationship, it matters not whether care workers are, as individuals, well meaning or act in accordance with personal or institutional values and principles. The issue is that if they did not, there would be little likelihood of redress. The fundamental point about republican liberty is that people should not be reliant upon

the goodwill or good judgment of others; there should be principles to guide judgement and structural safeguards against bad faith and poor judgments. As Lovett (2010b) puts it, liberty is not enhanced by making our master a better person, but by making him less of a master.

One interesting characteristic of republican liberty is that a person can be subject to de-centralised domination, whereby their options are 'more or less equally dismal' in any setting (Lovett, 2010a: 52-3). Lovett gives the example of a slave who may move from master to master, but will always experience domination in any of those relationships. For our purposes, it is important to recognise that whilst a person might be removed from a setting where they are subject to recognised abuses, they might still be dominated where they are moved to if the structural protections against such arbitrary interferences remain just as weak. It also means that a person might potentially be dominated across a variety of institutions which make up their 'care plan' if the protections in, for example, their care home and college or day centres are equally weak.

### 2.3.1 NECESSARY BUT INSUFFICIENT CONDITIONS OF DOMINATION: DEPENDENCY AND IMBALANCE OF POWER

In Lovett's (2010a) lengthy analysis of domination, he spells out various necessary, but insufficient, elements of domination besides exposure to arbitrary interferences. One of these is a relationship of dependency between the person who is being dominated and those dominating them. Lovett defines dependency as a relationship with 'high exit costs', which could include significant physical or financial losses if the dependent party tried to leave that relationship, but it could also include emotional or psychological losses. This is one reason why republican policy recommendations may emphasise the importance of social welfare provision, to ensure a person is not excessively dependent upon a spouse or employer for financial security (e.g. Pettit, 2002). Lovett also emphasises that *perceived* high exit costs can contribute towards dependency; the critical issue is that a person would feel unable to 'exit' that relationship.

People with learning disabilities will often be reliant on support from some source or another to help them live their lives. This means they are very likely to experience relationships with those that support them as having 'high exit costs'. In many situations the physical or practical means of 'exiting' those relationships may lie under the control of others. In some cases physical control may be exercised to prevent a person leaving a particular placement and hence the particular set of relationships of dependency within it. In other cases, people may not be able to leave a care service if they are reliant on commissioners to make alternatives available and 'best interests' decision makers to



approve those choices. Insofar as a person is unable to exercise control over where they live, is unable to leave that place, they have been surrendered to a set of relationships that contain at least one key ingredient of domination. The act of 'placement' of a person in a care service is not only potentially an arbitrary interference in itself, but also exposes people to further risks of domination within that service. It is striking how in all the reports and commentaries on recent abuse scandals in care,<sup>41</sup> almost none have discussed this one common feature: the residents were unable to escape their abusers as a result of their *de facto* or *de jure* confinement.

A second necessary but insufficient condition for states of domination is an imbalance of power between two people or groups. Lovett (2010a: 75) prefers a definition of social power from Weber (2002) as 'the probability that one actor within a social relationship will be in a position to carry out his own will despite resistance'. Lovett emphasises, however, that an imbalance of power is not in itself a form of domination as it does not necessarily bring in train the arbitrary exercise of that power. Lovett believes that many theorists of power haven't mistakenly conflated imbalances of power and domination.<sup>42</sup> He identifies two main forms of social power: 1) raising or lowering the costs and benefits of particular options, and 2) influencing a person's preferences over those options. To these, I suggest, we should add that a person might be 'enabled' to adopt certain options through practical support, or 'disabled' from selecting certain options by denying or removing the supports they rely upon. For the purposes of understanding domination in the context of caregiving relationships, attentiveness to power as opposed to interferences may be more useful. A person who is reliant on others to support them in their everyday lives may experience the potential for the arbitrary withdrawal of support as a form of domination as much as the potential for an arbitrary active interference.

### 2.3.2 CONSTRAINING ARBITRARINESS WHILST PROVIDING FOR DISCRETION

The critical issue for republicans is that the arbitrariness of the exercise of power is constrained. The republican prescription for addressing the problem of domination is for the exercise of social power to be constrained by clear and well known principles,

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<sup>41</sup> On Cornwall (Commission for Social Care Inspection and Healthcare Commission, 2006; Healthcare Commission, January 2007), on Winterbourne View (Bhaumik and Patterson, 2011; Bryan, 2012; Department of Health, 2012b; d; Emerson, 2012; Flynn, 2012; Mencap and Challenging Behaviour Foundation, 2012b; a; Rob Greig and other signatories, 2011; Rosenbach, 2011).

<sup>42</sup> Lovett includes Foucault in that category but this may be somewhat shallow reading of his works as Foucault does distinguish between power and domination, albeit that domination is slightly differently defined than in republican philosophy (Foucault, 1987; 1994b; Heller, 1996).

which are effectively enforced. However, providing clear and well known rules and principles to guide the exercise of power is notoriously problematic, a common theme in writings on the rule of law (Bingham, 2010; Dicey, 1885; Hart, H.L.A., 1961/1997; Dworkin, 1977; Lord Hewart of Bury, 1929; Waldron, 1989). Sainsbury (1992: 296) stresses that discretion is a much broader concept than most people realise, and is 'endemic' in welfare decision making. Discretion – understood as areas where legal actors enjoy choices (Hawkins, 1992) – is an area where moral, political, and social forces influence law's interpretation (Holmes, 1963). Even rule-based law may comprise elements of uncertainty, requiring considerable interpretation (Solan, 2012).

The European Court of Human Rights (ECtHR), whilst emphasising the importance of precision and foreseeability in the rule of law, has acknowledged that 'whilst certainty is highly desirable, it may bring in its train excessive rigidity'<sup>43</sup>. Any rules and principles laid down for those exercising power will need to afford them sufficient discretion to avoid injustice in the particular case, yet that discretion must be sufficiently constrained to avoid injustice through arbitrary and unequal treatment of alike cases. Furthermore, rules and principles must be responsive to social change.<sup>44</sup> Golder and Fitzpatrick (2009: 79) describe this as law 'constantly opening itself to new possibilities, new instantiations, fresh determinations'. This is why 'living instruments' like the ECHR<sup>45</sup> and welfare or best interests jurisdictions are explicitly linked to 'changes in our understanding of the natural world, technological changes, changes in social standards and, perhaps most important of all, changes in social attitudes'.<sup>46</sup> Yet that process of responding to change inevitably results in some temporary disturbances, and the potential for arbitrariness – in the short term at least.

Republicans are not deaf to the concern that the eradication of arbitrariness through the mechanical application of rules could lead to injustice in itself. Pettit (1997b: 175) recognises that 'having a dedicated, detailed rule for every situation' could deny all possibility of fitting action to the needs of particular cases. The republican solution to the dilemma of allowing for discretion without excessive arbitrariness is to turn to procedural justice and mechanisms of appeal and review (Lovett, 2010a: 100; Pettit, 1997b: 65). Discretionary decision makers must be 'exposed to sanction in the event of using that discretion in a way that is not properly controlled by non-sectional interest and judgement' (Pettit, 1997b: 65). Lovett (2010a: 96) describes this as an agent remaining 'answerable to a common-knowledge understanding of both the goals and aims it is

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<sup>43</sup> *The Sunday Times v United Kingdom* (App No 6538/74) [1979] ECHR 1 [49]

<sup>44</sup> See *The Sunday Times v United Kingdom* [49], 'the law must be able to keep pace with changing circumstances'.

<sup>45</sup> *Tyrer v United Kingdom* (1979-80) 2 EHRR 1 [31]

<sup>46</sup> *Re G (Children)* [2012] EWCA Civ 1233 [33], see also *J v C* [1970] AC 668, 722

meant to serve, and the means of achieving those goals and aims it is permitted to employ'. This emphasis on procedural justice accords with ECtHR jurisprudence which emphasises that 'Whenever discretion capable of interfering with the enjoyment of a Convention right... is conferred on national authorities' procedural safeguards ensuring that any measures of interference are fair, and which afford due respect to the person's interests, will be especially important.<sup>47</sup>

Republicans recognise that the existence of 'mere normative standards' is on their own will be insufficient to ameliorate states of domination – normative standards must be 'meaningfully backed by some sort of enforcement mechanism' (Lovett, 2010a: 97). This echoes ECtHR jurisprudence that the rights should be 'practical and effective', not 'theoretical and illusory'.<sup>48</sup> Republicans also emphasise that 'effective constraints must be *external* to the power wielding persons or groups themselves' (Lovett, 2010a: 100). This echoes the principle of natural justice that *nemo iudex in causa sua*<sup>49</sup> and Strasbourg jurisprudence on Articles 6<sup>50</sup> (the right to a fair trial) and 5(4)<sup>51</sup> (the right to court review of the lawfulness of detention). Unsurprisingly therefore, republicans regard law as a central means by which republican liberty can be secured (Pettit, 1997b: 173). However, few republicans have examined in close detail precisely how law might be enforced. Most seem to think primarily of 'self-starting'<sup>52</sup> mechanisms like litigation which require a person to recognise that their rights have been infringed and take action to 'invigilate' interferences which breach accepted principles (e.g. Pettit, 2008b). These are especially problematic for people with disabilities, for reasons which I explore more fully below and in Chapters 5 and 6. In this thesis I also include mechanisms which are not 'self-starting' such as non-directed advocacy and regulation.

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<sup>47</sup> *Buckley v The United Kingdom* (App no 20348/92) [1996] ECHR 39 [76]; see also *Glass v UK* (App no 61827/00) [2004] ECHR 103; (2004) 39 EHRR 15 and *X v Finland* (App no 34806/04) [2012] ECHR 1371 for further comments on the importance of procedural safeguards, such as an application to the court or an independent opinion, where Article 8 rights were engaged. Several recent cases which have considered the importance of procedural safeguards for deprivation of legal capacity proceedings will be discussed in subsequent chapters.

<sup>48</sup> *Airey v. Ireland* (App no 6289/73) [1979] ECHR 3; (1980) 2 EHRR 305 [24]

<sup>49</sup> Meaning 'no-one should be a judge in their own cause'. For the leading English case on the common law principle, see *R v Sussex Justices, Ex parte McCarthy* [1924] 1 KB 256; [1923] All ER Rep 233.

<sup>50</sup> *Pullar v UK* (App no 22399/93) [1996] ECHR 23 [3]

<sup>51</sup> See, for example, *Hutchison Reid v UK* (App no 50272/99) [2003] ECHR 9; (2003) 37 EHRR 9 [64]

<sup>52</sup> I have borrowed this term from Donnelly's (2010: 86) excellent book, where she comments 'actions in tort are inherently self-starting; they require an individual to initiate proceedings. This is something which patients who are most in need of mechanisms for empowerment may find most difficult to do.'

### 2.3.3 NON-DOMINATION AND NORMATIVE PRINCIPLES

Running through republican philosophy is a fault line over how far the substantive content of the normative principles constraining the exercise of power is relevant to whether or not a person is dominated. Pettit (1997b) argues that the normative principles of the 'republic' must have been derived through deliberative democratic means, and there must also be some constitutional mechanism for groups affected by laws to challenge their authority. By contrast, Lovett (2010a) argues that non-domination is secured so long as arbitrary power is effectively constrained by well known rules – no matter what their substance. Choosing a quite extreme example, he argues that even the Nazi's Nuremberg laws which prohibited European Jews from entering certain professions would not have been procedurally arbitrary, and hence not a form of domination. Lovett comments 'I argue that domination is a very bad thing. But it is by no means the only bad thing.' (Lovett, 2010a: 118-9).

For the purposes of this thesis, I will engage with Lovett's 'thin' or formal version of republicanism. This is not because his is morally or politically preferable to Pettit's democratic and welfare-oriented republican ideals – clearly it is not if the Nuremberg laws would be tolerated. However, the question of constraining arbitrary power is analytically distinct, and requires different research methods, from the historico-political question of whether or not normative principles were democratically derived, and the ethico-empirical questions of whether or not they are discriminatory or contribute towards the welfare of citizens.

This fault line between 'thick' and 'thin' conceptions of non-domination has some analogies with debates over the rule of law. Scholars such as Dicey and Raz hold that the rule of law has no necessary substantive content, whereas Unger, Dworkin and the late Lord Bingham hold that it does (Bingham, 2010; Craig, 1997). In a well known exchange the legal positivist H.L.A. Hart (1958) crossed swords with Lon Fuller (1958) over the relationship between law and morality. Hart maintained that law and morality were wholly separate. Fuller's response was that law itself 'must represent a human achievement' and was not 'a simple fiat of power or a repetitive pattern discernible in the behavior of state officials' and that 'even bad laws, have a claim to our respect' (p632). In later writings Fuller (1969: 162) put his case for an internal morality of law thus:

...legal morality can be said to be neutral over a wide range of ethical issues. It cannot be neutral in its view of man himself. To embark on the enterprise of subjecting human conduct to the governance of rules involves of necessity a commitment to the view that man is, or can become, a responsible agent, capable of understanding and following rules, and answerable for his defaults.

Fuller's argument appears very close to Lovett's in certain respects. Even if particular laws are ethically immoral in their substance, there is a residual morality in the rule of law itself. Rundle (2009a; 2012) applies Fuller's arguments to the Nuremberg laws. She argues that the earlier Nuremberg laws formalised *de facto* discrimination that was already taking place, and at least provided some stability, and 'a space within which agency, albeit highly and unjustly circumscribed, could be exercised' (Rundle, 2009b: 97; see also Arendt, 1965). However, later Nazi laws underwent a qualitative shift whereby the Jewish subject experienced decreasing expectations 'that he or she would be subject to predictable treatment by those in power' (Rundle, 2009b: 67). She argues that Fuller's critique of the Nazi laws is best understood as directed towards 'the level of uncontrolled administrative discretion that it empowers' (Rundle, 2009b: 56).

This thesis can best be understood as a critique of the MCA along similar lines to Rundle and Fuller's critique of the later Nuremberg laws; that its principles afford so much uncontrolled discretion to those exercising authority over adults with learning disabilities that the MCA violates the internal morality of law itself. This critique echoes one made by Lewis (2012a), that 'guardianship regimes... lack vital elements of the rule of law that we should not grace this system of commands as law'. This is not to say that, like the Nuremberg laws, the MCA is not *also* open to critique from other political or ethical perspectives – for example that it is discriminatory, or that it does not in practice promote the welfare of people with mental disabilities, as many contemporary criticisms connected with the CRPD make of it. These are important ethical, political and empirical questions, but they are not questions which are specifically addressed here. My purpose here is to subject the MCA to a critique on its own terms – as a piece of legislation that purports to impose the rule of law on the kinds of control exercised in the context of care.

#### 2.3.4 CONTRASTS WITH OTHER CONCEPTIONS OF 'LIBERTY'

A few other distinctions between republican and other important understandings of liberty must be spelled out before proceeding to discuss criticisms of the republican strategy. Firstly, as noted above, republicans strive to constrain the *arbitrariness* of interferences – not the quantity. This means that, as Lovett (2010b) notes, republican liberty is compatible with:

...living in a community where our lives are regulated down to the tiniest detail, but always in strict accordance with commonly-known, non-arbitrary rules and procedures. Although we enjoy extensive freedom from arbitrary power, we have hardly any freedom of individual choice.

Lovett observes that 'Most would not want to live in such a community', and suggests that we do place some independent value on non-interference, i.e. negative liberty, as

well as liberty as non-domination. I shall refer to the possibility of living in a community where one's life is regulated down to the tiniest detail as 'hyperregulation'. Importantly, even if the MCA did provide clear and well enforced principles for interferences in the fine detail of people's lives, hyperregulation would still be a possible outcome. Whether or not this is acceptable is a complex question, which would clearly require consideration of the substance of the rules and the context within which they were applied. This is not attempted in this thesis, although some examples of where hyperregulation might still be tolerated are discussed in the final chapter.

Republican liberty also differs from 'capabilities' approaches that stress the degree to which people enjoy 'real' substantive freedoms, such as bodily health, bodily integrity, use of the senses, imagination and thought, emotions and attachments, practical reason, affiliations with others, play and control over one's environment (Nussbaum, 2000). By contrast, Pettit (1997b: 94-7) considers that liberty is 'conditioned' but not 'compromised' by a lack of such opportunities. Capabilities approaches are derived from writings on international development and are closely associated with the work of Amartya Sen. They are increasingly cited in connection with disability rights (Centre for Disability Law & Policy, 2011; Crowther, 2007; 2010; Dhanda, 2003-4; 2006-7; Entwistle, 2012; Gombos and Dhanda, 2009; Mitra, 2006; Nussbaum, 2006; 2009; Stark, 2009; Stein, 2007). In this thesis I depart from Pettit's view that republican liberty is merely 'conditioned' by a lack of opportunities to enjoy substantive freedoms. As Arnardóttir and Quinn (2009) write, the civil and political rights of people with disabilities are closely intertwined with economic and social rights; examples of this will be given in this thesis. However, capabilities approaches have been critiqued as insufficiently sensitive to relations of dependency, power and hegemony (Dean, 2009), and in the sphere of disability as being insufficiently sensitive to needs for self-determination (Bérubé, 2009).

In a recent work Sen (2010: 306) helpfully sets out how republican and capabilities approaches are complementary, but distinct. He describes three scenarios for people with disabilities:

Case 1: Person A is not helped by others, and she is thus unable to go out of her house.

Case 2: Person A is always helped by helpers arranged either by a social security system in operation in her locality (or, alternatively, by volunteers with goodwill), and she is, as a result, fully able to go out of her house whenever she wants and to move around freely.

Case 3: Person A has well-remunerated servants who obey – and have to obey – her commands, and she is fully able to go out of her house whenever she wants and to move around freely.

In the first case, the person would enjoy no substantive ‘capabilities’. In the second the person is free in a ‘capabilities’ sense but not in a republican sense because their enjoyment of those capabilities is contingent on the goodwill of others. In the third case the person enjoys both capabilities and republican freedom, as their capabilities are resiliently secured against the arbitrary decisions of others. This thesis will not explore in depth whether people with learning disabilities enjoy all the substantive capabilities enumerated by Sen and other authors. However, Sen’s capabilities + republicanism approach appears more suited to exploring problems of domination in social care than Pettit’s concept of ‘conditioned’ liberty, as it recognises that people may be dominated through the threat of arbitrary withdrawal of support as much as active interferences.

One last form of ‘liberty’ must be distinguished from republican liberty. Berlin (1958) famously distinguished between ‘negative liberty’ – liberty as non-interference – and ‘positive liberty’ – which meant something more like freedom from inner constraints. Positive liberty is closely linked to what is often meant by ‘autonomy’, that is to say self-mastery or self-government. Autonomy is a highly prized virtue in Western society and is, as Hacking (2004: 283), observes, ‘astonishingly endemic to our religions and views of life’. An emphasis on guiding our behaviour through consciously selected principles for conduct can be discerned in writings as diverse as Kant (1886/1998) and the later thought of Foucault (1987; 1994b). Yet republican liberty is not synonymous with autonomy or positive liberty (Lovett, 2010b; Pettit, 1993; 1997b). Republican liberty is concerned with the arbitrariness of *outer* constraints, and although the term ‘autonomy’ is often used carelessly to mean something more like freedom from outer constraints this is not the predominant use philosophers have put it to (Buss, 2008; Freyenhagen, 2009). Republican liberty can, at best, clear a space where any external interferences one is subject to by other people are predictable, where there is no value in ‘bowing and scraping’ to others, and where one’s own personal autonomy can flourish.

## 2.4 CRITIQUES OF THE ‘TURN TO LAW’

The ‘turn to law’ for social transformation in general, and the emancipation of people with mental disabilities in particular, has been criticised for a range of reasons. At their heart, the critique is that legal strategies – including rights-based strategies – do not rupture the status quo, and will often re-inscribe or retrench inequalities and oppressive power relations. For example, Rosenberg (2008) has famously described the ‘turn to law’ for social change as a ‘hollow hope’. He argues that the nature of legal rights are too limited, the courts are not sufficiently independent from the legislature and the executive, and they lack the power to implement their decisions. Some campaigners

have turned away from using law to advance disability rights, arguing that it is too easily co-opted for other ends (Oliver and Barnes, 2006). Several authors describe rights-based strategies for social transformation as 'paradoxical' (Brown, W., 2002; Douzinas, 2007; Scott, 1996).

From this perspective, republican strategies are at best naïve and ineffective, and at worst they are potentially damaging in themselves. Lobel (2006: 939) calls this category of concerns 'cooptation' and describes cooptation as 'a process by which the focus on legal reform narrows the causes, deradicalizes the agenda, legitimizes ongoing injustices, and diverts energies away from more effective and transformative alternatives.' Some of these concerns will be outlined here but, following Lobel, I argue that despite the risks of cooptation there are reasons for persisting with the kinds of legal strategies envisaged by republicans.

#### 2.4.1 THE COLONIZATION OF LAW BY 'DISCIPLINARY POWER'

Mental health law is a category of law that is intended to hold in check a form of power that Foucault (1977) referred to as 'disciplinary'. The work of disciplinary agents is informed by norms derived from the human sciences, such as criminology, psychology, sociology. Such agents are vested with authority to make judgments in accordance with these norms; Foucault (1977: 204) complained that in modernity:

The judges of normality are present everywhere. We are in the society of the teacher-judge, the doctor-judge, the educator-judge, the 'social worker' judge.

The task of the mental health professional, social worker, or even care workers, is to label and interpret a person according to disciplinary discourses and forms of knowledge, and apply disciplinary techniques to bring their behaviour and circumstances into accordance with disciplinary norms. There is clear overlap between Foucault's writings on disciplinary power and Goffman's (1961: 22) observation that total institutions are 'forcing houses for changing persons; each is a natural experiment on what can be done to the self'.

It is often observed that instead of law, and mental health law in particular, holding the power of disciplinary agents in check, law can itself become 'colonised' by disciplinary power (Bartlett and Sandland, 2007: 347; Hunt and Wickham, 1994; Wickham, 2002). Critical legal scholars have observed that law often tends to absorb and reinforce the authority of medical expertise and knowledge, and can act as a 'rubber stamp' on the acts of disciplinary agents. Fennell (1986: 36-37) has described how - far



from law and psychiatry existing 'in a relationship of mutual antagonism' - law in fact resolves the legitimacy problem that psychiatry faces in the absence of patient consent.

In a very worthwhile commentary, sadly too complex to recount in great detail here, Golder and Fitzpatrick (2009) have a more nuanced take on the relationship between disciplinary power and law as a mutually 'enabling relay' (p27). Law, they argue, needs disciplinary power to provide acceptable 'scientific' and 'objective' seeming norms to inform its decisions, and law relies upon disciplinary agents to implement its edicts. Meanwhile law *validates* the norms of disciplinary power and masks the inherent instabilities and insufficiencies of the truth claims of the human sciences. Furthermore, by seeming to act as a restraint on disciplinary power, and sometimes reigning in its most egregious excesses, law gives the quotidian acts of disciplinary agents a veneer of legitimacy; it leaves the centre unchallenged. Golder and Fitzpatrick also emphasize that whilst, in modernity, law is highly interrelated with disciplinary power, this relationship is contingent and not essential. Law's perdurance rests in its ability to adapt to and absorb new and emerging forms of power – it is always incipiently other than it is. Accordingly, therefore, we should be alert to the possibility that law will reveal openings to other forms of power, and their associated agencies, discourses and knowledge claims, which may not be disciplinary in character.

## 2.4.2 ACCESSING AND USING THE MACHINERY OF LAW

Wendy Brown (2002: 423) writes that 'rights differentially empower different social groups, depending on their ability to enact the power that a right potentially entails'. Commenting on Gostin's rights-based legal strategy for mental health patients, Rose (1985: 212-4) points to the way legal strategies unequally empower according to who is able to exercise those rights, exacerbating the disadvantaged position of those without support and advocates. Repeat players who are familiar with the legal system become more adept at using it to secure their interests, and their interests will consequently shape the development of the law (Galanter, 1974). Several authors have expressed concern that people with disabilities, being less able to access the law, are unable to 'bend' it to respond to their concerns (Mladenov, 2012; Russell, 2002). There is a danger that the concerns of people with mental disabilities will be invisible in the canon of law, or subordinated to the interests of others, because of inequalities in access.

Brown also draws attention to the reality that rights 'cannot be adjudicated in abstraction from the bureaucratic juridical apparatus through which they are negotiated'. Using this apparatus 'may subject us to intense forms of bureaucratic domination and regulatory power even at the moment that we assert [our rights] in our own defense'

(Brown, 1995: 121, fn41; cited by Golder, 2011). Luban (1994: 2621) describes litigation as ‘expensive, terrifying, frustrating, infuriating, humiliating, time-consuming, perhaps all-consuming.’ Republicans rarely address in any great detail the practical difficulties of navigating legal machinery, nor the possibility that these difficulties may be greater for some sections of the population than others. Yet this must be regarded as an essential element of any empirical analysis of the problem of domination. Consequently this thesis will pay careful attention to the accessibility of the legal and regulatory machinery for enforcing the MCA, and the potential for forms of domination to emerge within this machinery itself.

### 2.4.3 LAW CREATES NEW POWER RELATIONS, WHICH MUST THEMSELVES BE CONSTRAINED

Legal strategies for social transformation are often discussed in the context of ‘rights’, and ‘rights’ are often conflated with limiting the powers of the state and checking the decisions and acts of the executive (e.g. O’Cinneide, 2012). Yet, as Ivison (2007) and Souter (2008) point out, rights do not merely rein in power, but can also act as conduits for power, creating new power relations and therefore new potential for emergent forms of domination.

A good example of this from the cannon of rights is protecting ‘vulnerable’ citizens – usually children or people with disabilities – from harms inflicted by themselves or others. A right to protection brings with it a concomitant duty upon the state to act, typically upon both the alleged victim and the alleged perpetrator of harm. Republican approaches place a great deal of emphasis on the state’s ability to constrain the arbitrary interferences of private actors, as well as the executive. Republicans endorse, for example, the use of children’s ‘rights’ to protect them from arbitrary interferences by their parents and teachers (Pettit, 1997b). Yet in doing so, they potentially ‘introduce new (legal) forms of domination into the community’ (Ferejohn, 2001: 88-9). Lovett (2010b) writes that republicans need to be ‘on guard against the introduction of new forms of dependency and arbitrary power through those very laws and policies designed to enhance individual freedom’.

### 2.4.4 THE IMPLIED LEGAL SUBJECT

Inscribed at the heart of law is a set of beliefs about the nature of legal subjects themselves. Such beliefs are typically closely aligned to a particular view of Man found in post-Enlightenment, liberal philosophy. Writers as diverse as the feminist scholars

Joan Wallace Scott (1996) and Wendy Brown (2002), and the ‘conservative liberal’<sup>53</sup> Lord Hoffman (2009) have observed that rights based strategies tend to presuppose a moral and political philosophy of man as a self-reliant, rational and unencumbered agent. For Fuller (1969: 162), a view of man as ‘a responsible agent, capable of understanding and following rules, and answerable for his defaults’ is central to the morality of law itself, and a departure from that morality ‘is an affront to man’s dignity as a responsible agent.’ Yet clearly this is a philosophy of man which sits uncomfortably with the very concept of ‘incapacity’; it threatens that incapacity – whatever that means – potentially subverts the very logic and morality of law itself.

Presumptions about the abilities of legal subjects are built into the machinery of law. This means that without adaptation to take into account a broader range of legal subjects, legal strategies will be substantially weakened for those who do not meet prevailing expectations of the legal subject. Self-starting mechanisms of law enforcement presume that legal subjects are able to identify when their rights are violated and are willing and able to defend them. Non-directed mechanisms of enforcement have important potential, but they may also serve to filter out beliefs and behaviours which are disruptive to ordinary legal processes, rather than solely serving to overcome access to justice difficulties. The machinery of law needs careful calibration to ensure the voices of those with differing needs, abilities, perspectives and ways of being in the world are not excluded from justice. As several authors have noted, it will be impossible to secure the civil and political rights of people with disabilities without attending to their economic, social and cultural rights (Arnardóttir and Quinn, 2009; Mladenov, 2012; O’Cinneide, 2009).

Fyson and Cromby (2012: 1-2) observe that a view of man as ‘endowed with reason and conscience’<sup>54</sup> is inscribed into almost all human rights instruments. Yet, they argue, this presumption is not met for people with learning disabilities and they call for a more ‘relational’ understanding of autonomy. Quinn (2011b) has also argued that the cognitive essentialism that underpins common conceptions of law and justice is problematic for people with mental disabilities; he terms this the ‘myth of the masterless man’. Quinn also calls for a more relational understanding of personhood to inform our ideas around law and justice. Indeed, ‘relational autonomy’ is a common trope in writings on Article 12 CRPD (e.g. Dimopoulos, 2010; Gooding, 2012; Francis and Silvers, 2010; Silvers, 2011; Silvers and Francis, 2009; Bach and Kerzner, 2010). The difficulty is that what is meant by ‘relational autonomy’ is often not well cashed out. One senses that what Quinn and those writing in connection with the CRPD might have in

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<sup>53</sup> As described by the BBC (Broome et al., 2012).

<sup>54</sup> See Article 1 Universal Declaration of Human Rights (United Nations, 1948).

mind could be quite different to writers such as Fyson and Cromby, Dunn (2008) and Herring & Foster (2012), who do not appear to advocating for disabled people to enjoy greater choice and control in their lives or critically engaging with the concept of 'incapacity'. Holroyd (2009: 321) has observed that philosophies advocating 'relational' approaches to autonomy 'cannot play one of autonomy's key normative roles: identifying those agents who ought to be protected from (hard) paternalistic intervention'. Whilst they may represent an important step towards a more inclusive legal subjectivity, they also threaten to cloud some important distinctions that have a bearing on liberty and domination. The influence of relational approaches, and the complex legal, ethical and metaphysical questions they generate, can be observed in the case law of the MCA, explored in Chapter 4.

#### 2.4.5 SHOULD WE ABANDON LEGAL STRATEGIES?

Despite these rather pessimistic writings on the emancipatory potential of law, almost none of the authors cited here have discounted that legal and rights-based strategies could play *some* kind of limited emancipatory role for oppressed groups. Perhaps the least optimistic of all, Brown (2002: 431) writes that 'rights for the systematically subordinated tend to rewrite injuries, inequalities, and impediments to freedom... Yet the absence of rights in these domains leaves fully intact these same conditions'. Even whilst critiquing rights as the 'credo of the middle classes', Douzinas (2007: 33) observes that:

Every time a poor, oppressed, tortured person uses the language of rights - because no other is currently available - to protest, resist, fight, she draws from and connects with the most honourable metaphysics, morality and politics of the Western world.

Despite arguing that rights-based strategies are non-progressive, Rose (1985: 214-5) concedes that they might useful for symbolic 'guerrilla' assaults on particular practices or institutions, because of their appeal to Western social and political 'common sense'. Fennell (1986: 59), responding to Rose, acknowledges that the rights of mental health patients may be limited, but comments that legal strategies have the potential to 'open up areas of the psychiatric system to scrutiny which might otherwise remain hidden ...and require those who operate the system to reflect on and justify what they are doing'. Even Foucault, with his anarchic leanings, has obliquely suggested in interview that 'rules of law' may have a part to play in reducing 'the effects of domination which will make a child subject to the arbitrary and useless authority of a teacher, or put a student under the power of an abusively authoritarian professor, and so forth' (1987: 129). Pettit (1997b: 177) is adamant that 'For those who suffer oppression, criticism of the rule of law

as 'bourgeois justice' or 'liberal legalism' can only be perceived as naive or heartless, or both'.

Even if one takes a pessimistic view of legal strategies, as Lobel (2006) observes one cannot 'opt out' of law itself in our society. Statutes, case law, rules and regulations will continue to develop with or without the input of reformers; the alternative to legal strategies for reform is that reform and law develop in opposing directions. Furthermore, without law the alternative suggestions for constraining domination in hitherto 'private' and unregulated relationships are extremely limited. These critiques of the 'turn to law' are important reality checks and qualifiers on the perhaps-too-optimistic republican prescription for the problems of domination. However, we should be cautious of allowing them to play into conservative rhetorics of deregulation, the inevitability of inequity and injustice, and demands for unconstrained authoritarian power.



# CHAPTER 3 – RESEARCH METHOD

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## 3.1 INTRODUCTION

This thesis considers how far the MCA and the DoLS help to secure freedom from institutional domination for adults with learning. Republican theorists identify two key ingredients for securing republican liberty:

- Clearly defined and well known principles setting out permissible interferences with people’s choices and freedoms by those in a position to interfere;
- Effective and independent mechanisms for enforcing those principles.

For the problem of institutional domination, the critical question is how far the MCA reduces arbitrariness in admissions to institutions and in interferences with people’s everyday choices and freedoms by institutional authorities.

There is no tradition of ‘empirical’ testing of republican hypotheses. There are, however, a range of research methods which could be used to consider whether the MCA satisfies the republican prescription for the problem of institutional domination. In common law jurisdictions, case law is a primary means by which legal principles are developed and expanded or refined, and so doctrinal research methods play a central role in exploring how clearly the MCA defines principles for permissible interferences in institutional care. However, republican approaches also question how well the law is disseminated to its subjects and understood by them. Republicans consider both legal and extra-legal mechanisms of enforcement to be important, evoking more ‘socio-legal’ research questions (Cotterrell, 2002).

Inevitably, it would not be possible to cover all these aspects of the MCA in a single thesis. Instead, this thesis confines its ambitions to: 1) providing a preliminary mapping of the principles the courts have developed from the MCA which relate to the problems of institutional domination described in Chapter 2; and 2) exploring some of the main mechanisms by which it was envisaged the MCA would be enforced. Some of the concerns about the ‘turn to law’ will also be considered along the way where they help to explain how the law has fallen short of some progressive aspirations. This is by no means intended to be an exhaustive republican analysis of the MCA, but simply a starting point for one way of critiquing the Act.

## 3.2 PRINCIPLES FOR THE EXERCISE OF POWER BY INSTITUTIONAL AUTHORITIES

In Chapter 4 I use doctrinal methods to consider how far the common law has developed principles related to the MCA which could constrain the kinds of arbitrary interferences which affect adults with learning disabilities in institutional care. By structuring this doctrinal analysis according to the areas of concern drawn from the literature review, rather than those areas which are most ‘active’ in case law, it became apparent that there are many areas of concern where the law falls silent. From a republican perspective, these gaps and silences are of great significance – they are areas where the principles for interferences of a particular nature are not well developed, and consequently where law is not constraining the risk of arbitrary interferences. Through exploring various access to justice issues in later chapters, I am able to show how various filters may make some issues more or less likely to come before the courts. Consequently, I am able to describe how accessibility issues shape the evolution of legal principles, whilst certain matters are filtered out of the legal sphere.

### 3.2.1 LIMITATIONS FOR ANALYSES OF JUDGMENTS OF THE COURT OF PROTECTION

A doctrinal analysis of rulings from the Court of Protection presents significant methodological difficulties. Publication of a judgment is at the discretion of the presiding judge.<sup>55</sup> Many judgments are delivered *ex tempore*, and only a very small proportion of cases result in a published judgment or law report. Publication of information about a case without the permission of the presiding judge is a contempt of court.<sup>56</sup> I have written elsewhere about the difficulties for the Court of Protection in balancing litigants’ Article 8 ECHR rights to private life and the growing demand for greater transparency in the court’s practices (Series, 2012d). In that article I show that there are even judgments that appear to have been of legal significance and have been relied upon in subsequent cases, that have not yet been published. I endorse arguments made by Munby LJ (2010) and Sir Nicholas Wall (2012) for the routine publication of anonymised judgments unless there is compelling evidence that to do so would jeopardise the wellbeing of litigants or the fairness of proceedings.<sup>57</sup> For research purposes the following points should be born in mind:

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<sup>55</sup> r91 Court of Protection Rules 2007

<sup>56</sup> s12(1)(b) Administration of Justice Act 1960

<sup>57</sup> Similar arguments might also be inferred from Lord Neuberger’s (2012) recent keynote address, entitled ‘No Judgment – No Justice’.



- The cases analysed here do not form a complete record of the work of the Court of Protection; it may well be that there are unpublished cases which would be relevant to the problems of institutional domination.
- During the course of my research I have encountered unpublished cases, or additional information about cases that have been published, which I would like to be able to discuss. However, it would be a contempt of court to publish this information in this thesis.
- Issues related to institutional domination may well be considered by the courts, yet not emerge in the judgment.

Even where judgments are published, dissemination is a real problem with decisions from the Court of Protection. To help the reader locate any judgments I describe in this thesis, and understand why I have sometimes adopted unorthodox citation schemes, the following information may be of assistance:

- There is, now, an official series of Court of Protection Law Reports (COPLR)<sup>58</sup>, but there can be significant delays between the appearance of a judgment in the public domain and its publication there. As my institution does not subscribe to the COPLRs, I have only rarely used their citation scheme.<sup>59</sup>
- For reasons which are unclear, the British and Irish Legal Information Institute (BAILII)<sup>60</sup> publishes only a very small proportion on Court of Protection judgments on its website.<sup>61</sup> Wherever possible I have tried to use the neutral citation number for a judgment if it is given in the transcript, however these cases do not necessarily appear on the BAILII website, nor on Westlaw or Lexis Nexis.
- The best source for obtaining judgments from the Court of Protection is an independently run website called Mental Health Law Online (MHLO).<sup>62</sup> Where no neutral citation is available, I have used the MHLO's own, new, citation scheme to help locate the judgment.
- Some cases for which there is no published judgment are reported in the widely read Court of Protection newsletter published by barristers at 39

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<sup>58</sup> Published by Jordans Publishing, Bristol. There is a consolidated volume of the COPLR for cases falling between 2008-11, and subsequent updating volumes for more recent cases.

<sup>59</sup> There are a few exceptions to this where I have only been able to locate cases in the COPLR in my copy of the consolidated volume.

<sup>60</sup> [www.bailii.org](http://www.bailii.org)

<sup>61</sup> For example, it published only 20 for the year 2011, despite the Court of Protection issuing thousands of property and affairs orders and hundreds for care and welfare.

<sup>62</sup> [www.mentalhealthlaw.co.uk](http://www.mentalhealthlaw.co.uk)

Essex St.<sup>63</sup> When a case is not reported anywhere else I have given a reference to the relevant edition of the newsletter where it is described.

The record is incomplete and fragmentary, yet in itself this is a key finding. Republicans require that the principles governing permissible interferences are not only clear, but also that they are well known. A perfectly clear ruling cannot address the problem of institutional domination, unless it is in the public domain and effectively disseminated. The methods of disseminating Court of Protection judgments give real cause for concern from a republican perspective.

### 3.2.2 INFORMATION MANAGEMENT TECHNIQUES FOR DOCTRINAL ANALYSIS

Although the volume of published judgments is low in contrast with the number of cases being heard, there were still a considerable amount to contend with. I used two methods to organise these materials. Each judgment was stored in reference management software (Endnote X5) and categorised with key terms which referenced key themes in the research, for example 'restraint' or 'medication'. Some areas of law were extremely complex, with many emergent themes and issues; in particular the DoLS and ECtHR rulings on legal capacity. To trace important themes and ideas through these areas I uploaded judgments onto the qualitative research software NVivo, and carefully coded each judgment for issues, arguments and legal reasoning.

This proved to be an extremely useful technique for exploring the complexities of these areas of law. To give one example, the meaning of deprivation of liberty (discussed in Chapter 6) for people who 'lack capacity' is fast evolving. After coding 30 Court of Protection and ECtHR judgments I developed 188 'nodes', of which 31 related to reasons considered by a court why a person might, or might not, be considered to be deprived of their liberty. This made it easy to see which themes were dominant in the courts' reasoning, and to bring up examples of these.

## 3.3 MECHANISMS ENFORCING THE PRINCIPLES OF THE MENTAL CAPACITY ACT 2005

Clearly it would be impracticable to survey all the mechanisms which might be used to enforce the MCA, and all the details of their operation in practice. I chose to focus on five key mechanisms: Independent Mental Capacity Advocates (IMCAs); litigation in the Court of Protection; complaints to the LGO; regulation of care services by the CQC; and the DoLS. I selected litigation in the Court of Protection because it is

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<sup>63</sup> Back copies of this newsletter are available on MHLO here: [http://www.mentalhealthlaw.co.uk/39\\_Essex\\_Street\\_COP\\_Newsletter](http://www.mentalhealthlaw.co.uk/39_Essex_Street_COP_Newsletter)

the key mechanism established by the MCA for determining legal questions about capacity and best interests. I chose IMCAs because their role was created by the MCA in response to concerns about the lack of accessible mechanisms for enforcing the MCA. Similarly, I included DoLS because they are a mechanism for enforcing the principles of the MCA created by the statute itself. I included complaints mechanisms because they are mentioned as a means of dispute resolution in several places in the MCA code of practice (Lord Chancellor's Office, 2007: [10.37], [15.19]-[15.21], [15.30]-[15.32]). I included regulation of care services by the CQC because regulation has always been a key element of legalism, and because the CQC has a statutory obligation to 'protect and promote the rights' of people who are deprived of their liberty under the MCA.<sup>64</sup>

I also undertook research on enforcement of the MCA through disciplinary and professional regulation mechanisms, and the enforcement of the MCA through the criminal law.<sup>65</sup> Interesting though these findings were, a decision was taken to exclude them from the thesis for reasons of space and parsimony.

### 3.3.1 RESEARCH INTERVIEWS

Early on in the research, before deciding on a theory to apply or area of focus, I interviewed several social care practitioners to understand what issues were of particular interest or concern for those working regularly with the MCA. To understand the purpose of these interviews, it is helpful to give some background for how the project arose. The project was funded by the European Social Fund (ESF).<sup>66</sup> The ESF funding arose out of a development project in Cornwall which recognised it as one of the most deprived areas of the European Union.<sup>67</sup> The ESF helped to fund a Cornish satellite campus for Exeter University,<sup>68</sup> to improve rates of higher education in the County. Funding for a small number of postgraduate studentships was included, of which mine was one. The projects were very loosely defined; mine was entitled 'Medico-Legal Questions of Capacity and Consent with especial reference to the Care of the Elderly & Mentally Impaired', but had few further specifications or constraints. This gave me considerable freedom, but meant that it took some time for me to select which of several possible avenues for research I would pursue.

These early interviews could (very) loosely be described as 'grounded' in approach (Charmaz, 2004; 2005), and helped to supplement and guide the early stages of the literature review and doctrinal research. I began by identifying key

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<sup>64</sup> s4(1)(d) Health and Social Care Act 2008

<sup>65</sup> Either via the accused relying upon the 'general defence' under the MCA, or the offence of ill-treatment or neglect under s44 MCA.

<sup>66</sup> Dossier no. 09099NCO5

<sup>67</sup> More information about this project is available here: <http://www.dwp.gov.uk/esf/>

<sup>68</sup> The campus also includes University College Falmouth.

professionals working with the MCA and with people with learning disabilities in Cornwall, and approached them via their institutions for interview. I also used snowball sampling, where participants suggested another person who would have another important perspective on the MCA. These early interviews were with social workers, lay advocates, a care home manager, a CQC inspector and people who provided training on the MCA and the DoLS.

These early interviews were wide ranging and open textured. For each interview I prepared a very loose set of questions about how the MCA related to a person's area of work, what they felt worked well, and where they felt there were difficulties. Depending on the participant, interviews focussed on the relationship of the MCA to: adult safeguarding, community care assessment and commissioning, person-centred care planning, direct payments, care home inspection, and advocacy for people with learning disabilities and carers. The interviews gave me a sense of how these different areas interlinked, and how some concerns resonated across all areas. Although it was not a source of data for this thesis, some participants were kind enough to allow me to attend training courses on safeguarding, community care law, advocacy, welfare benefits and human rights for care workers to develop my understanding of these areas.

Interviews each took between 1-2 hours, and took place in a person's workplace, in a room at the university, or at a neutral location such as a café – depending on participants' preferences. At the end of each interview I gave participants a small gift of chocolates or biscuits as a token of my gratitude for them giving up their time. I took notes and made audio-recordings. Recordings were not transcribed in full, but I listened back to them to check the accuracy of my notes. In the rare cases where I used a quotation I took it from the audio-recording rather than my notes. One interview, with the CQC inspector, was conducted by telephone for practical reasons. In this interview I only took notes, but I sent them the minutes to check and amend for accuracy. This method had the benefit of enabling the person to add additional thoughts which came to them at a later date, and for them to clarify areas of uncertainty which remained in my notes. It was a method I came to use for later interviews (discussed below). Although notes were taken for each interview they were not systematically coded as the purpose was to gain a sense of which areas my research could be directed towards, not to develop a theory of the field as a whole.

Inevitably, many areas with important research potential emerged, and my selection reflected where my personal interests coincided with areas of concern for participants. I decided not to pursue research into the relationship between capacity and Direct Payments, which was an issue raised by many participants. The DoLS were raised as an area of confusion and concern by several social workers, the care

home manager and the CQC inspector. A common theme was the degree of restrictions people with learning disabilities live under. A second area of concern expressed by almost all participants was a perceived lack of scrutiny of the care of people with learning disabilities and accessible mechanisms they could use to assert their rights. Many participants made reference to the abuse of adults with learning disabilities in Cornwall (Commission for Social Care Inspection and Healthcare Commission, 2006) when making this point, no doubt because the scandal was both recent and local. These became the two key themes I pursued in my research: to what extent does the MCA proscribe, or even produce, the restrictions that people with learning disabilities live under, and to what extent are they able to use the law to challenge them?

Later on, when the research was better established, I used further interviews to answer particular questions which I could find no answers to in the research literature, through doctrinal or other methods. For example, I interviewed members of DoLS teams to ask for examples of how they used conditions in DoLS authorisations. I asked IMCAs what they did if they felt a person wished to challenge a best interests decision but the IMCAs themselves agreed with it. I contacted judges, solicitors and the Official Solicitor to ask specific questions about court processes and procedures. These interviews were semi-structured; I would work through set of questions I had prepared specifically for that interview, but often interviewees would often alert me to other issues which I then took away to research. By the end of the research, the sample of people interviewed looked like this:

**Table 1 Professional role and gender of interview participants**

	Professional role of interview participants	Number of professionals interviewed
Later interviews	Solicitors	3
	Judges	4
	The Official Solicitor	1
	IMCAs	3
Earlier interviews	CQC compliance inspector	1
	DoLS assessors or managers	3
	Social workers (other than DoLS)	1
	Workforce trainers in mental capacity, human rights or 'person centred care'	4
	Care home manager	1
	Advocates (other than IMCAs) working with people with mental disabilities or	3

		family carers
Gender of interview participants	Male	9
	Female	15
TOTAL		24

For these later interviews, I took field notes instead of audio-recordings. Two were conducted over the telephone. I would then write minutes of what was said, and send it back to the participant for them to check and amend as appropriate. As the purpose of these interviews was to find out specific information about the workings of MCA-related procedures, I was not concerned with capturing an accurate record of conversational exchanges,<sup>69</sup> but rather an accurate record of how they viewed a process as working. A small number of participants, all judges, preferred an ‘off the record chat’ rather than the interview being cited as a source of data. These interviews were nevertheless extremely useful for guiding me towards other sources of information to answer any questions I had which I could then cite in the research.

Because the sample of participants from any given group was small, it was difficult to generalise from their experiences. Consequently, relatively few references are made in the body of this thesis to these interviews. Quotations are generally used sparingly to illustrate and enliven the text rather than provide evidence of a particular feature of the operation of the Act. An exception to this is where a particular interview participant was a sufficient authority on a particular matter (for example, the Official Solicitor on the workings of his office), or for a small number of matters where no other sources of information were available.

### 3.2.2 ANALYSIS OF REPORTS OF REGULATORS AND OMBUDSMEN

Although case law has a particular significance from a legal perspective because it lays down a precedent, the MCA has been interpreted and enforced via a range of bodies other than the courts. For this thesis, I have also looked at reports by the LGO and the CQC. I undertook a number of ‘micro-studies’ of reports by both bodies, to explore how they have interpreted and applied the MCA with reference to care services.

I used the LGO’s search engine to identify all their published decisions which related to the MCA.<sup>70</sup> Using the Freedom of Information Act 2000 (FOIA) I was also able to obtain copies of unpublished investigations relating to the deprivation of liberty

<sup>69</sup> I did not use a research method – such as Conversation Analysis (Sacks, 1992), for example – where preservation of an accurate transcript of the exchange is essential.

<sup>70</sup> See Appendix B, Study B5.

safeguards. A brief summary of all LGO reports I was able to locate which referenced 'mental capacity'<sup>71</sup> is given in Appendix B, and these reports are discussed in the body of the thesis in Chapters 4, 5 and 6.

For the CQC, I undertook small 'audits' of inspection reports I downloaded from the CQC's website.<sup>72</sup> One study looked at how often CQC inspectors reported findings relating to the MCA, the DoLS and associated concepts. The second study looked at how inspectors gained information about the experiences and perspectives of people with learning disabilities using residential care services. The methods used for these studies are reported in more detail as Study B1 and Study B2 in Appendix B, and I draw from their findings in Chapters 5 and 6.

### 3.3.3 FREEDOM OF INFORMATION ACT 2000

In addition to research interviews I also made extensive use of the Freedom of Information Act 2000 (FOIA) to obtain additional 'grey' literature, consultation responses, policy materials, or statistical or other unpublished quantitative data on the practical implementation of various mechanisms. The FOIA is an increasingly important tool in the academic armoury (Bourke et al., 2012), and was absolutely indispensable in carrying out this research. I also found the FOIA useful to follow up claims made by interview participants that would benefit from independent verification, or to assess the extent to which particular problems were more widespread than the participant's own experience.

Although data obtained under the FOIA is publicly obtainable it is not – usually – in the public domain in any easy to access form. Nor is there any standardised method of citing a request made under the FOIA, so far as I am aware. Consequently, I have presented some of the data I obtained under the FOIA in appendices to this thesis, so the reader can confirm for themselves that it supports the arguments I am making. I have also created a referencing system in order to refer to particular FOIA requests I made when these form the basis of arguments or assertions in the body of this thesis.

The details of each request are given in Appendix A, including the name of the body the information was requested from, the dates of when the request was made and the information was supplied, details of the substance of the request and any issues arising from it. In many cases I made the requests via third party websites or they were published by the institution I requested the data from. I have provided the URL link to that information where available. In some cases I have placed documents or data in a

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<sup>71</sup> I included in my searches related concepts like 'consent', 'best interests', and 'capacity' as often the term 'capacity' is used without specific reference to the MCA or 'mental' capacity.

<sup>72</sup> See Studies 2 and 3 in Appendix A

public folder on my 'Dropbox' account<sup>73</sup>, and I have given the URL to this folder so that it can be freely accessed over the internet. In a small number of cases I have also used data collected using the FOIA by other persons than myself. In some cases this was data collected via third party websites which I happened across whilst searching for materials – in which case the URL is provided. In other cases, it was data collected by journalists or researchers which they kindly shared with me by email – in which case I have attributed its provenance to them accordingly in the FOIA table in Appendix A.

So, for example, (FOIA #1) relates to the first entry in the table in Appendix A, which is a request made by myself to the Office of the Public Guardian on 6th June 2012, who responded on 20th June 2012. The substance of the request was 'Demographic data on people with deputies or active LPAs; Number of complaints by P about his LPA and deputy, number of investigations proceeding from those complaints.' The request was made by email.

### 3.5 OTHER APPROACHES, NOT ADOPTED IN THIS THESIS

As discussed in Chapter 2, both Pettit and Lovett recognise that there are other sources of normative principles which might constrain the exercise of power than law, and other – social – means by which those principles might be enforced. As such, they would doubtless have sympathy with legal pluralism in socio-legal scholarship (Cotterrell, 2006; Ehrlich and Isaacs, 1922). It is acknowledged that the normative ordering endorsed by the MCA runs in parallel to, and intersects with, several other normative orderings found in society relating to the care and control of adults with learning disabilities. For example, some parent carers have expressed anger with the MCA, 'which assumes an adult with learning disabilities can make his or her own decisions unless it is proved otherwise' (Monckton, 2012). Adults with learning disabilities are sometimes infantilised as people who 'will stay a child for ever' (Reilly, 2012), a discourse which legitimates control by analogy to parental authority over young children rather than by reference to 'incapacity'. Exploring and understanding how these non-legal discourses of control intersect with the MCA is an important endeavor, but unfortunately it is one which lies beyond the scope of this thesis.

Early on in this doctoral research I undertook a series of interviews with care workers and family carers which explored discourses around autonomy, risk and protection, and examined these through the lens of 'legal consciousness' (Silbey, 2008). The findings were striking, but as I wanted to focus first on the interpretation and enforcement of the MCA through more central legal channels I took the decision to exclude this material from the thesis. This thesis is already very long and detailed, and

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<sup>73</sup> 'Dropbox' is a form of cloud storage, which enables users to share files and folders with third parties, see: [www.dropbox.com](http://www.dropbox.com)



the inclusion of this material would have required extensive additions in order to do justice to both the research method and the findings. They could have formed an entirely separate thesis. Hopefully these interviews will form the basis of a future, separate, publication.

Consequently, although this thesis acknowledges that the MCA does not represent a unique source of principles influencing the control of adults with learning disabilities, and does not claim that more formal legal and regulatory channels are the sole means by which the MCA is interpreted and enforced, these remain the focus of this thesis. Despite an important trend towards research on the 'informal' workings of law, and law's wider effects on society and individuals, I believe there is still a case for examining its more central machinery alongside. There is a developing empirical literature on the implementation of the MCA – mostly generated by researchers with medical, social policy or social work backgrounds. There is also a developing medical ethics literature on the MCA. However, the Act's central mechanisms and procedures remain under-theorised.

Early socio-legal scholarship focused on the 'gap' between 'law on the books' and 'law in action' (Pound, 2010; Sarat, 1985). This research identifies a significant gap between the MCA 'on the brochure' as an instrument of empowerment, and the ways in which the law's machinery can be put to practical use by disabled people. There is, I believe, much to be learned about the MCA, and attitudes towards legalism itself, from studying its development, its mechanisms and the ways in which various bodies have interpreted and applied it.

### 3.6 RESEARCH ETHICS

In accordance with university guidelines, I applied to the Research Ethics Committee for all aspects of this research which 'involved human participants'. Based on advice from the ethics committee, I did not seek approval for any 'formal' correspondence with public officials (including, but not limited to, FOIA requests), but all interviews were subject to the University's ethical research review procedures. In line with guidance from the Economic and Social Research Council (2012) and the Socio-Legal Studies Association (2009), all research participants were given an information sheet and the opportunity to consider and ask questions about participation. Information sheets covered issues about the funding of the research, the nature of the project, data protection and any limitations on the confidentiality which could be guaranteed in connection with a safeguarding protocol I developed (discussed below).

For some interview participants there were particular issues around confidentiality and anonymity which had to be addressed. I produced a separate

information sheet for judges, and I also corresponded by email with the Official Solicitor (OS) and some other participants whose identities might be difficult to disguise to ensure they were aware of this risk. Written consent on a consent form was sought from participants at the beginning and end of all the early stage interviews. Where an interview was conducted via telephone I did this via post and also sought express verbal consent. For interviews with judges and solicitors I took consent via email, after having sent them detailed information about the issues I would like to discuss, the use the information would be put to, and receiving their feedback on the form of interview they felt most comfortable with. I also took verbal consent before any interviews.

The research also raised challenging ethical questions around what would happen if safeguarding concerns emerged during the interview and whether it would be appropriate to breach a participant's confidence in such circumstances. I developed a protocol for such scenarios after consulting with my supervisor, the local authority safeguarding team and the ethics committee. For research in health and social care settings, it is commonly assumed that breach of confidence is required where 'safeguarding' concerns are raised, but research based in a university carries no clear expectations to that effect. It was challenging to balance participants' expectations of confidentiality against potential harm to others. The protocol specified that breaking a participant's confidence would only be contemplated after the matter had been discussed with them and it was felt that they did not understand or feel inclined to address particular concerns, or where a person was in real and immediate danger. The information sheet and consent form carried information to this effect, and it was conveyed verbally prior to taking consent. Fortunately this problem never transpired.

# CHAPTER 4 - THE STRUCTURAL PILLARS OF THE MENTAL CAPACITY ACT 2005

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## 4.1 INTRODUCTION

Although one can never ‘read off’ the purpose of a law, it is instructive to contemplate the origins of the MCA to understand the social and legal framework it emerged from, and to appreciate what concerns, and whose, it responded to. Whilst the MCA is often presented as an instrument of emancipation, a way to ‘empower’ adults with mental disabilities and to help them reclaim more ‘autonomy’, it is hard to discern this goal from the developments in its earlier history. In support of my claim that the MCA was not primarily geared towards empowerment, I offer a short description of the development of Article 12 CRPD - the right to equal recognition before the law. The CRPD is of more significance than a mere biographical contrast to the MCA, however, the UK is legally bound to implement its provisions under international law, and it is increasingly influential in the interpretation of ECHR case law on legal capacity. Furthermore, many themes in the literature associated with the CRPD, such as ‘relational autonomy’ and ‘independent living’ are increasingly appearing in MCA case law, and so it is useful to examine how this legal instrument deals with these.

### 4.1.1 THE UN CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES

In Beijing in 2000 a conference of international and national disability rights NGO’s issued a call to arms, to ‘strive for a legally binding international convention on the rights of all people with disabilities to full participation and equality in society’ (Disabled Peoples International et al., 2000). The ‘Beijing Declaration’, as it is known, sought the ‘Elimination of discriminatory attitudes and practices, as well as information, legal and infrastructural barriers’ which contributed to the exclusion of disabled people from full participation in society. The CRPD represented the culmination of decades of work by disability rights campaigners (Quinn et al., 2002), lengthy and sometimes heated negotiations between disabled people’s organisations and state parties, and it was a treaty that spoke directly from and to the experiences of disabled people. The influence of the ‘British’ social model of disability (Oliver, 1990a; Oliver, 1990b) is discernible in the definition of disability adopted by Article 1 CRPD:

Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with

various barriers may hinder their full and effective participation in society on an equal basis with others.

Copious provisions addressing equality and non-discrimination are imbued with the ideals of North American 'civil rights' and Scandinavian 'normalisation' models of disability.

Several elements of the CRPD might be regarded as tackling the segregation and containment of disabled adults in 'total institutions'. Article 3 calls for 'Full and effective participation and inclusion in society', whilst Article 19 CRPD establishes a right to independent living which it defines as:

...the opportunity to choose their place of residence and where and with whom they live on an equal basis with others and are not obliged to live in a particular living arrangement.

Article 14 CRPD prohibits deprivation of liberty on disability related grounds, whilst Article 17 endows a right to respect for 'physical and mental integrity on an equal basis with others'. Of most direct relevance to this thesis, Article 12 CRPD calls upon state parties to 'recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life'. Article 12 requires state parties to provide the support people need to exercise their legal capacity and ensure there are safeguards on any such measures which:

...respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person's circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body.<sup>74</sup>

Articles 12, 14 and 17 CRPD were among the most contentious during the drafting of the CRPD (Dhanda, 2006-7; Lawson, 2006-7; Minkowitz, 2006-7), and their interpretation is still a matter of dispute. Debates around Articles 14 and 17 are, in many respects, merely situation-specific elaborations of the core issue underpinning disputes around Article 12: whether it is ever acceptable to override a person's legal rights to self determination on disability related grounds. Article 12 is said to be 'the most revolutionary of the new norms articulated in the CRPD' (Minkowitz, 2006-7), to represent a 'paradigm shift' (Bach and Kerzner, 2010; Centre for Disability Law & Policy, 2011; Dhanda, 2006-7; 2011; Equal Rights Trust, 2008; European Disability Forum, 2009; Maina, 2009; World Network of Users and Survivors of Psychiatry, 2011b; a), and to lie at the core of the CRPD (Quinn, 2011b). Some interpret Article 12 to prohibit all forms of 'substituted decision making' on disability related grounds (Dhanda, 2011; Minkowitz, 2006-7), although not everybody agrees with this

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<sup>74</sup> Article 12(4)

interpretation.<sup>75</sup> However, on the basis of their first five state reports,<sup>76</sup> the CRPD Committee<sup>77</sup> appears to interpret Article 12 as requiring the replacement of all laws permitting substituted decision making with provision for supported decision making (United Nations Committee for the Rights of Persons with Disabilities, 2012b; 2011b; a; 2012c; a).

Legal academics (Bartlett, 2012b; a; Richardson, 2012) and a senior Court of Protection judge (Lush, 2012) have suggested that Article 12 CRPD creates obligations that may conflict with the MCA, the MHA and potentially the ECHR as well (Fennell and Khaliq, 2011). Article 12 caused the most problems for state parties in ratifying the CRPD (Equal Rights Trust, 2008). Several countries around the world are attempting to reform their legal capacity laws to bring them in line with the CRPD. In the Republic of Ireland, a bill<sup>78</sup> that is very similar to the MCA has met with widespread opposition from civil society groups, many of whom argue it is not compatible with Article 12 CRPD (Age Action Ireland et al., 2012; Centre for Disability Law & Policy, 2011; Houses of the Oireachtas Committee on Justice Defence and Equality, 2012; Quinn, 2012). In India the Ministry of Social Justice and Empowerment is sponsoring a draft bill<sup>79</sup> that closely resembles many provisions of Article 12 CRPD, and contains radical provisions for new arrangements for supported decision making. Sadly it is beyond the scope of this thesis to examine in any great detail what would be a 'correct' or workable interpretation of Article 12 CPRD.

Several debates and discussions around Article 12 have implicated 'incapacity' as a legal mechanism which facilitates the institutionalisation of disabled people (Hammarberg, 2012; Human Rights Brief, 2012; Lewis, 2011; 2012b; Office of the High Commissioner for Human rights, 2012; Parker, 2011; Quinn, 2011b). Tracing out some of the connections between 'incapacity' under the MCA and institutionalisation is a central goal of this thesis. The CRPD is also increasingly used as an aid to interpretation in ECtHR<sup>80</sup> and domestic<sup>81</sup> case law. Although Article 12 CRPD has yet

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<sup>75</sup> In particular, the UK government appears not to regard Article 12 as prohibiting substituted decision making as it regards the MCA as compatible with the CRPD (Office for Disability Issues, 2011), and neither does Senior Judge Lush (2011) of the Court of Protection. Canada and Australia lodged explicit reservations against the CRPD to the effect that they interpreted Article 12 as permitting substituted decision making.

<sup>76</sup> At the time of writing, these states included: Tunisia, Spain, Peru, China and Hungary.

<sup>77</sup> The CRPD Committee was created by the Convention to monitor state reports. For states, including the UK, which have ratified the CRPD's optional protocol, the CRPD Committee also have competence to hear individual complaints that the CRPD has been breached.

<sup>78</sup> Draft Mental Capacity Bill (Ireland) 2008

<sup>79</sup> The Draft Rights of Persons with Disabilities Bill, 2012

<sup>80</sup> See: *Alajos Kiss v Hungary* (Application no. 38832/06) [2010] ECHR 692; *D.D. v Lithuania* (App no 13469/06) [2012] ECHR 254; *Đorđević v Croatia* (App No 41526/10) HEJUD [2012] ECHR 1640; *Glor v Switzerland* (App. No.13444/04) (30 April 2009); *Kędzior v Poland* (App. No.45026/07), Statement of Facts, May 14, 2009; *Seal v United Kingdom* (App no 50330/07) [2010] ECHR 1976; *Stanev v Bulgaria* (App no 36760/06) [2012] ECHR 46

to make an appearance in domestic case law, it was recently influential in two important and recent rulings on incapacity and institutionalisation: *Stanev v Bulgaria*<sup>82</sup> and *D.D. v Lithuania*<sup>83</sup>. Doubtless sooner or later the UK will have to grapple with the compatibility of the MCA and Article 12 CRPD in some legal or diplomatic arena.

#### 4.1.2 THE ORIGINS OF THE MENTAL CAPACITY ACT 2005

Bersani distinguishes between three 'waves' of the disability movement for people with learning disabilities: the first wave represented the voice of professionals, the second the voice of carers and the third the voice of people with learning disabilities themselves (Bersani, 1996; Wehmeyer et al., 2000). If the CRPD is an instrument of the third wave, the MCA must be regarded as primarily an instrument of the first wave, with some substantial influence of the second and very little from the third. Whilst the founding of the CRPD was a call to arms from disabled peoples' organisations to establish a treaty to promote rights and freedoms, the germ for the MCA was a series of court cases where the medical and legal establishment sought to protect professionals who wished to *interfere with* their choices and freedoms. Whatever the post-legislative sales-pitch for the MCA, in the case law and literature which preceded it one finds little talk of 'empowerment', 'equality', 'inclusion' – the primary impulse for the creation of the MCA was a legal framework which would permit interferences in order to protect, to control.

#### THE DECLARATORY JURISDICTION

In response to concerns that guardianship under the MHA 1959 was paternalistic, sexist, outdated and afforded guardians excessive and ill-defined powers (Law Commission, 1991), the MHA 1983 significantly curtailed the powers of guardians.<sup>84</sup> A redefinition of mental disorder also meant that people with learning

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<sup>81</sup> See: *AM (Somalia) v Entry Clearance Officer* [2009] EWCA Civ 634; *Burnip v Birmingham City Council & Anor* (Rev 1) [2012] EWCA Civ 629; *R (AM) v The City Council & Anor* [2009] EWHC 688 (Admin); *R (Cardiff County Council) v The Welsh Ministers* [2009] EWHC 3684 (Admin); *R (NM) v London Borough of Islington & Ors* [2012] EWHC 414 (Admin); *R(NM) v Secretary of State for Justice* [2011] EWHC 1816 (Admin) and *R (NM) v Secretary of State for Justice* [2012] EWCA Civ 1182; *R. (McDonald) v Kensington and Chelsea LBC* [2010] EWCA Civ 1109; *X Endowed Primary School v Special Educational Needs and Disability Tribunal & Ors* [2009] EWHC 1842 (Admin).

<sup>82</sup> (App no 36760/06) [2012] ECHR 46

<sup>83</sup> (App no 13469/06) [2012] ECHR 254

<sup>84</sup> The 'essential powers' of guardians under s8 MHA include powers to 'require the patient to reside at a place specified by the authority or person named as guardian', to 'require the patient to attend at places and times so specified for the purpose of medical treatment, occupation, education or training' and to 'require access to the patient to be given, at any place where the patient is residing, to any registered medical practitioner, approved mental health professional or other person so specified.'

disabilities who were not ‘abnormally aggressive or seriously irresponsible’<sup>85</sup> were not eligible for guardianship, or detention, under the MHA. The effect of these restrictions on the use of guardianship was that, in the words of the Law Commission (1991: [3.5]), ‘There was no longer any machinery for assuming responsibility for every aspect of a completely incapacitated person’s life’. The case of *Re F. (Mental Patient: Sterilisation)*<sup>86</sup> established that there were no longer any legal powers to consent to medical procedures on behalf of people who lacked the capacity to give or refuse consent themselves. Consent to medical treatment was not an ‘essential power’ of guardians, and the ancient *parens patriae* jurisdiction of the court had been abolished several decades before.<sup>87</sup>

On paper at least, the situation was that substituted decision making on behalf of people with mental disabilities had been abolished for a wide variety of decisions, and in particular for health and welfare decisions.<sup>88</sup> What happened next should be a salutary lesson for those seeking to abolish all forms of substituted decision making who would rely upon the common law to provide solutions for situations of risk and crisis. In *Re F* the House of Lords, finding that there was no lawful authority to consent to a sterilisation operation on behalf of a woman with learning disabilities, invoked the common law doctrine of necessity. They found that if an act of care or treatment was in the ‘best interests’ of a person who lacked the mental capacity to consent to it, then a defence of ‘necessity’ was available for acts of care and treatment. Doubtless few today would regard sterilisation of a disabled woman as ‘necessary’,<sup>89</sup> but such is the flexibility of the ‘great safety net which lies behind all statute law and is capable of filling gaps left by that law’.<sup>90</sup>

During the years that followed the ruling in *Re F*, until the MCA came into force, the courts heard a series of cases under what became known as its ‘declaratory jurisdiction’ concerning mental capacity and best interests. In order to show who sought to make use of the declaratory jurisdiction and the kinds of issues which were

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<sup>85</sup> s1(2A) MHA 1983

<sup>86</sup> [1991] UKHL 1; [1990] 2 A.C. 1

<sup>87</sup> By the revocation by Warrant under the Sign Manual of the last Warrant on 10 April 1956.

<sup>88</sup> There were, however, powers for the ‘old’ Court of Protection to take control of a person’s financial affairs, but that court had no powers to make decisions around medical treatments or welfare issues.

<sup>89</sup> Stansfield, Holland and Clare (2007) report that between 1988-99 the Official Solicitor received 79 referrals for sterilisation operations. Of these, 39 resulted in a court hearing and 31 found that it was in a person’s best interests to be sterilised. Since the coming into force of the MCA there have been no reported cases concerning sterilisation, although one case arose which concerned contraception (*Re A (Capacity: Refusal of Contraception)* [2010] EWHC 1549 (Fam)) and one application from a mother for her daughter to be sterilised was withdrawn (Daily Mail, 2011; McVeigh, 2011).

<sup>90</sup> Lord Donaldson in the Court of Appeal hearing of *Re F. (Mental Patient: Sterilisation)*, cited in *Re F (Adult Patient)* [2000] EWCA Civ 3029.

came to be considered justiciable under the court's new 'best interests' jurisdiction, I have grouped them as follows:

- 1. Applications from medical professionals, concerned about liability for carrying out – or failing to carry out – medical treatments without capable consent.** Proposed treatments included blood transfusions,<sup>91</sup> termination of a pregnancy,<sup>92</sup> haemodialysis,<sup>93</sup> experimental treatments,<sup>94</sup> an emergency caesarean section<sup>95</sup> and naso-gastric feeding of anorexia patients.<sup>96</sup> Applications from health professionals were also successful in securing declarations that reasonable force could be used to administer treatments<sup>97</sup> and that patients could be denied access to their personal files<sup>98</sup> where it was in their best interests. Declarations regarding capacity and best interests were also sought by medical professionals regarding *inaction*, to the effect that a patient had capacity to refuse treatment.<sup>99</sup> Similar declarations were sought in respect of prisoners on hunger strikes.<sup>100</sup> In some cases applications were made to the court for declarations that cessation of life-sustaining treatment,<sup>101</sup> or refraining from life-saving treatment,<sup>102</sup> was in the best interests of an unconscious patient, and hence lawful.
- 2. Applications from family members, seeking declarations that particular medical treatments would be in a person's best interests.** After *Re F* several cases came from mothers seeking declarations that it was in the best interests of their sons<sup>103</sup> or daughters<sup>104</sup> for them to be sterilised. In *Re Y (Mental Patient: Bone Marrow Donation)*<sup>105</sup>, the parents of a 'severely mentally handicapped' woman applied to the court seeking a declaration that it was in her best interests to undergo an invasive and painful operation in order to donate bone marrow to her sibling, who would otherwise be very likely to die.

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<sup>91</sup> *X NHS Trust v T (Adult Patient: Refusal of Medical Treatment)* [2004] EWHC 1279 (Fam); [2005] 1 All ER 387

<sup>92</sup> *D v An NHS Trust (Medical Treatment: Consent: Termination)* [2003] EWHC 2793 (Fam); [2004] 1 FLR 1110

<sup>93</sup> *A Hospital NHS Trust v S* [2003] EWHC 365 (Fam); [2003] Lloyd's Rep. Med. 137

<sup>94</sup> *Simms v Simm* [2002] EWHC 2734 (Fam); [2003] Fam. 83; [2003] 2 WLR 1465

<sup>95</sup> *Re MB* [1997] 2 FLR 426

<sup>96</sup> *Riverside Mental Health NHS Trust v Fox* [1994] 1 FLR 614

<sup>97</sup> *Norfolk v Norwich Healthcare (NHS) Trust* [1996] 2 FLR 613

<sup>98</sup> *R v Mid Glamorgan Family Health Services Ex p. Martin* [1995] 1 WLR 110

<sup>99</sup> *Re JT (Adult: Refusal of Medical Treatment)* [1998] 1 FLR 48

<sup>100</sup> *Secretary of State for the Home Department v Robb* [1995] Fam. 127

<sup>101</sup> *Airedale Hospital Trustees v Bland* [1992] UKHL 5; *NHS Trust A v M* [2001] Fam. 348; [2001] 2 WLR 942; *An NHS Trust v X* [2005] EWCA Civ 1145; [2006] Lloyd's Rep. Med. 29

<sup>102</sup> *Frenchay Healthcare NHS Trust v S* [1994] 1 WLR 601

<sup>103</sup> *Re A (Mental Patient: Sterilisation)* [2000] 1 FLR 549

<sup>104</sup> *Re S (Adult Patient: Sterilisation: Patient's Best Interests)* [2000] 1 FLR 465

<sup>105</sup> [1997] Fam. 110; [1997] 2 WLR 556



3. **Applications by a family member to resolve a dispute with other family members over a person's welfare.** In *Re C (Mental Patient: Contact)*<sup>106</sup> C's mother sought a declaration granting regular access to her daughter, which she said was being obstructed by her father. The court found that this potentially engaged tortious acts through restricting C's freedom, and therefore the court could make such a declaration. In *Re S (Hospital Patient: Court's Jurisdiction)*<sup>107</sup> the court was asked whether a man who had suffered a stroke should return to live with his estranged wife, or with his common law partner. This ruling, and later cases concerning where an adult should live,<sup>108</sup> saw the court establish a declaratory jurisdiction for the lawfulness of wider welfare questions than potentially tortious acts. Some have questioned what authority the court was purporting to exercise in these cases (Bartlett, 2008: [2.19]).
4. **Applications from local authorities, often in dispute with family members, regarding the welfare of an 'incapable adult'.** In *Re F (adult patient)*<sup>109</sup> the Court of Appeal found that there were no longer any statutory<sup>110</sup> or *parens patriae* powers that could be used to prevent the return of a young woman who had just turned 18 from local authority care to her parents, where there were concerns around inadequate care and sexual abuse. The Court of Appeal found that the only option available to the court was to make a 'best interests' declaration, relying upon the doctrine of necessity, regarding residence. In *Re S (Adult Patient) (Inherent Jurisdiction: Family Life)*<sup>111</sup> Sheffield City Council sought a declaration from the court that it was in S's best interests that he live in council provided accommodation, and contact with his father be restricted. Munby J found that the court could act as a 'surrogate decision maker' for S and choose between living with his father or in council provided accommodation on his behalf. In *Re Z (Local Authority: Duty)*<sup>112</sup> a local authority sought an injunction to prevent a husband assisting his wife, who had cerebella ataxia, from travelling to a clinic in Switzerland for the purpose of assisted suicide. They failed to secure the injunction as the court found that Z had the mental capacity to make the decision herself.

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<sup>106</sup> [1993] 1 FLR 940

<sup>107</sup> [1996] Fam 1 (CA)

<sup>108</sup> *Re TF (An Adult: Residence)* [2000] 1 MHLR 120

<sup>109</sup> [2000] EWCA Civ 192

<sup>110</sup> In an earlier hearing, *Re F (Mental Health Act: Guardianship)* [2000] 1 FLR 192, the court had held that the definition of mental disorder under s1 MHA should be restrictive interpreted, meaning that guardianship could not be used for most adults with learning disabilities. The Court of Appeal hearing reaffirmed this.

<sup>111</sup> [2002] EWHC 2278 (Fam); [2003] 1 FLR 292

<sup>112</sup> [2004] EWHC 2817 (Fam); [2005] 1 WLR 959

5. **Applications to the court by adults with disabilities to prohibit a particular treatment, by asserting that they have the mental capacity to refuse to consent to it.** In *Re C (Adult: Refusal of Medical Treatment)*<sup>113</sup> a man with paranoid schizophrenia applied to the court for an injunction against amputation of his gangrenous leg. The court heard medical evidence that without the amputation C would almost certainly die, but found – through the application of a ‘functional test’ of capacity – that C had capacity to make the decision to refuse treatment.<sup>114</sup> In *Re W (Adult: Refusal of Medical Treatment)*<sup>115</sup> a man was found competent to refuse treatment for a leg wound and possible ensuing septicaemia which would lead to his death. In *Ms B v An NHS Hospital Trust*<sup>116</sup>, the court found that a woman who had suffered spinal damage resulting in tetraplegia had the mental capacity to refuse ongoing life sustaining treatment. In *Re T (adult: refusal of medical treatment)*<sup>117</sup> the OS appealed on behalf of a woman who had lost consciousness against the administration of a blood transfusion which she had previously refused on religious grounds. The court found that she had lacked the capacity to do so, having been subject to ‘undue influence’.
6. **Applications made to the court by adults with disabilities to assert their autonomy in respect of other welfare issues.** In one published case, *Re V (A Minor) (Injunction: Jurisdiction)*<sup>118</sup>, a disabled young man applied to the court to seek a declaration that upon reaching majority age he was entitled to choose where he lived, and injunctive relief restraining his mother from impeding his freedom to choose. He was concerned that his mother did not respect his autonomy in making this decision.

There are several striking characteristics of these cases. The first is that the vast majority of them concerned medical treatment, not matters of care and welfare in community settings. The largest group of cases were brought by medical professionals seeking protection from liability for particular acts or omissions. A small proportion came from family members either seeking some kind of treatment, often quite controversial treatments, or to resolve disputes with other family members. The use of the declaratory jurisdiction by local authorities in dispute with families, and relatives in dispute with each other, was also tentatively established. The use of the court by

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<sup>113</sup> [1994] 1 All ER 819

<sup>114</sup> This case was to form the basis of the ‘functional test’ of capacity that can now be found in s3(1) MCA.

<sup>115</sup> [2002] EWHC 901 (Fam); [2002] MHLR 411

<sup>116</sup> [2002] EWHC 429 (Fam)

<sup>117</sup> [1992] EWCA Civ 18; 4 All ER 649

<sup>118</sup> [1995] 2 FLR 1003

disabled people seeking to assert their rights to self-determination was minimal. Questions around involuntary placement in social care institutions, or restrictions within institutional life, are virtually absent. It was in these cases, with their focus on one-off - largely medical - decisions that the 'structural pillars' (Dimopoulos, 2010) of the functional test of capacity and the concept of best interests were developed.

### AN EMPOWERING STATUTE?

Alongside the development of the declaratory jurisdiction, the Law Commission began a lengthy program of research aimed at closing the 'legal lacuna' for lawful authority to make decisions on behalf of people deemed to lack capacity (Law Commission, 1989; 1991; 1993a; b; c; 1995). Their research was prompted not only by these court cases, but also by a Law Society discussion paper that expressed concern about the lack of powers to intervene in what would today be called 'adult safeguarding' matters (Letts, 1989). The Law Society emphasised that the legal lacuna extended far wider than the healthcare matters that dominated the courts. The approach adopted by the Law Commission built upon the 'structural pillars' established under the declaratory jurisdiction and reflected a preference for 'informality' of approach to the care and treatment of people with mental disabilities (Law Commission, 1991: [4.14]-[4.20]). The focus of the architects of the MCA – courts and Law Commission alike – was thus primarily protective and paternalistic. A related focus was to provide a means of resolving disputes over care and welfare within and between families and professionals. This 'social protection' impetus, which inspired the MCA, is identified as a 'disempowering' framework by disability campaigners associated with the CRPD (Minkowitz, undated; Mladenov, 2012: 5). Unlike the drafters of the CRPD, the drafters of the MCA were not primarily animated by concerns of social exclusion, paternalism and institutionalisation.

On one view, therefore, the MCA was never meant to be an 'empowering' act at all; it evolved to *facilitate* paternalistic interferences not to limit them. Yet this view is not entirely fair if one looks at what was occurring in the wider social field at this time. Although the formal powers of guardians had been significantly curtailed by the MHA 1983, and were little used before that (Fennell, 1992), the MCA did not enter a social field where people with mental disabilities were free of paternalistic interferences, coercion and control. Such acts were no doubt occurring, but largely occurred outside of any legal framework.<sup>119</sup> Bartlett and McHale (2003) contend that the novelty of the legal lacuna during the years of the declaratory jurisdiction 'was largely illusory': concerns arose because of 'a set of cultural changes, both within and without law',

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<sup>119</sup> Wicks (2013: 5-6) writes that *Re F* 'amended the law to bring it into line with what was almost certainly happening anyway'.

whereby decisions that were previously considered to be private family matters became legally salient. There were, as Hale (2009b: 113) notes, no clear principles governing what could be done in informal settings, and no obvious procedures for resolving doubts and difficulties. A key function of the MCA was making such decisions legally salient, providing principles for interferences and a mechanism for the resolution of doubt and dispute.

By 2002 several disability organisations<sup>120</sup> formed the influential 'Making Decisions Alliance' (MDA) to lobby the government to introduce mental incapacity legislation, and to increase public awareness of the need for it.<sup>121</sup> They suggested some amendments<sup>122</sup> and pushed for the inclusion of advocacy provision, which resulted in the creation of Independent Mental Capacity Advocates (IMCAs).<sup>123</sup> The homepage on the MDA's website stated 'it's a basic human right to be able to make your own decisions and yet millions of people are discriminated against and their right to make their own decisions is ignored everyday because of a lack of comprehensive legislation to protect this right.'<sup>124</sup> How did an Act which would *facilitate* substituted decisions in the absence of any statutory authority to do so come to be seen as protecting people's rights to make them?

One answer is that it wouldn't; that the idea of the MCA as 'empowering' or promoting autonomy (Lord Chancellor's Office, 2007: foreword, [1.4])<sup>125</sup> is at best muddled wishful thinking, at worst a cynical sales pitch from first and second wave groups who would be given authority and protection by the Act. Yet republicanism does offer one perspective on how the MCA might, if not 'empower', at least *ameliorate* states of domination: by providing clearer and principles for the exercise of paternalistic authority and a means to challenge it. The MCA might be most sympathetically understood as an effort to regulate hitherto unregulated, but actually occurring,

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<sup>120</sup> The following organisations were MDA members:

Action on Elder Abuse; Age Concern England; Alzheimers Concern Ealing; Alzheimer's Society; Beth Johnson Foundation; Carers UK; The Centre for Policy on Ageing; Cloverleaf Advocacy; Consumer Forum; Different Stokes; The Down's Syndrome Association; Foundation for People with Learning Disabilities; Headway; Help The Aged; Horsham Gateway Club; Independent Advocacy Service; Kent Autistic Trust; Leonard Cheshire; Mencap; The Mental Health Foundation; Mind; Motor Neurone Disease Association; The National Autistic Society; North Staffordshire Users Group; The Oaklea Trust; Patient Concern; Powerhouse; The Relatives and Residents Association; Respond; Rethink; Rett Syndrome Association (UK); St Clements Patients Council; Scope; Sense; Skills for People; The Stroke Association; Turning Point; United Response; WITNESS.

<sup>121</sup> Information on the MDA kindly supplied by Toby Williamson, who co-chaired the MDA.

<sup>122</sup> For examples, whereas the Law Commission (1995: 195) had recommended that a person should not be regarded as unable to understand information relevant to the decision, if they would be able to understand an explanation of it 'in broad terms and simple language', the MDA (2003) recommended support for non-verbal communication as well, and consequently s(2) MCA references 'visual aids or any other means' of supporting understanding.

<sup>123</sup> The IMCA service is discussed in Chapter 5.

<sup>124</sup> The website is no longer online, but an archived version was kindly shared with me by Toby Williamson.

<sup>125</sup> See Chapter 1 for references making this claim.

exercises of social power. One might draw parallels with arguments that the early Nuremberg laws of Nazi Germany, by legislating for *de facto* discrimination which was already occurring, at least stabilised the predicament of Jewish subjects.<sup>126</sup> Like the Nuremberg laws example, one can reserve criticism for the abhorrent substance of those laws, yet still agree that if power is being exercised in such a fashion then it is better that it is done in a predictable and stable way.

The restrictive powers that are exercised in social care - confinement, coercion, control – did not wait for law to give them permission, they were already being exercised; the MCA attempted to impose some checks and limits on what was already occurring.<sup>127</sup> Yet for this republican and rule of law argument to be sustainable, the MCA must provide clear principles for any interferences which it permits, and they must be effectively enforced. This chapter will address the first part of that question by exploring how clear the principles of the ‘structural pillars’ of the MCA are in respect of the problems of institutional domination of adults with learning disabilities. The next two chapters will address how effectively these principles are enforced.

The MCA has been praised for its ‘elegance’ (Bowen, 2007) for providing, in a few short paragraphs of statute, a set of principles which can be deployed across an almost limitless set of legal questions. Yet elegant and flexible principles inevitably require considerable interpretation in order to be applied to real life scenarios, and herein creeps the risk of arbitrariness. On a republican view, discretionary powers are permissible only so long as an agent ‘remains answerable to a common knowledge understanding of both the goals and aims it is meant to serve, and the means of achieving those goals and aims it is permitted to employ’ (Lovett, 2010a: 96; see also Pettit, 1997b: 65). In this section I will explore how case law, other influential soft-law materials such as reports of the LGO, and Serious Case Reviews (SCR)<sup>128</sup> have fleshed out the structural pillars of the MCA. I will consider whether these have provided ‘clear principles’ for particular issues connected with institutional domination of adults with learning disabilities.

## 4.2 THE ‘GENERAL DEFENCE’

There are four main mechanisms through which the MCA permits acts or decisions to be made on behalf of people who lack capacity in their best interests:

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<sup>126</sup> This example is given by Lovett (2010a) and Rundle (2009a; 2012) and discussed at greater length in Chapter 2.

<sup>127</sup> This point is reminiscent of Foucault’s observations that power comes ‘from below’ and does not ‘emanate’ from a ‘central point’ such as the sovereign (Foucault, 1976: 93).

<sup>128</sup> Serious Case Reviews are often conducted by local authority social services departments ‘safeguarding’ boards following a serious untoward incident which affected a person who used social care services. SCRs are not compulsory, but they are regarded as good practice. They are usually written by independent experts, and seek to ‘learn lessons’ rather than apportion blame (Association of Directors of Adult Social Services, 2010).

1. Through the 'general defence' of s5 and s6 MCA;
2. Through Lasting Powers of Attorney (LPA) documents, whereby a person (the 'donor') gives another person (the 'donee') powers to make certain decisions on their behalf;
3. By a single welfare order of the Court of Protection under s16 MCA;
4. Through the Court of Protection appointing a deputy under s16(2) MCA with powers to make particular decisions on behalf of a person.

Data obtained under the FOIA from the Office of the Public Guardian<sup>129</sup> (OPG) revealed that a very low proportion of LPA's are registered by younger individuals.<sup>130</sup> This suggests that LPAs tend to be used by older people rather than people with developmental disabilities reaching adulthood; many adults with learning disabilities might never be regarded as having the capacity to make an LPA at all. Deputyships for personal welfare matters are very rarely used.<sup>131</sup> Consequently, the most likely source of authority for the vast majority of personal welfare decisions affecting adults with learning disabilities is the 'general defence' of s5-6 MCA.

The general defence provides that:

5(1) If a person ("D") does an act in connection with the care or treatment of another person ("P"), the act is one to which this section applies if—

(a) before doing the act, D takes reasonable steps to establish whether P lacks capacity in relation to the matter in question, and

(b) when doing the act, D reasonably believes—

(i) that P lacks capacity in relation to the matter, and

(ii) that it will be in P's best interests for the act to be done.

(2) D does not incur any liability in relation to the act that he would not have incurred if P—

(a) had had capacity to consent in relation to the matter, and

(b) had consented to D's doing the act.<sup>132</sup>

Protection from liability extends only as far as the person's consent would have done had they the capacity to consent, or refuse consent, to the act.<sup>133</sup> The provisions for

<sup>129</sup> A body established by the MCA to register and supervise the activities of LPAs and deputies.

<sup>130</sup> In the months of April and May 2012 only 0.22% of LPA's were registered by individuals under the age of 29, and fewer than 3% under the age of 50 (FOIA #1).

<sup>131</sup> s16 MCA was drafted to discourage the use of deputyships. The Court of Protection appointed only 106 welfare deputies in 2010, and 112 in 2009 (Judiciary of England and Wales, 2010; 2011).

<sup>132</sup> s5 MCA 'Acts in connection with care or treatment'

restraint are more stringent. Restraint is defined as the use, or threat of use, of 'force to secure the doing of an act which P resists' or restriction of 'P's liberty of movement, whether or not P resists'.<sup>134</sup> In order to rely upon the 'general defence' for acts of restraint, an agent must additionally reasonably believe that it is necessary to restrain P in order to prevent harm to P.<sup>135</sup> The act of restraint must also be 'a proportionate response to ...the likelihood of P's suffering harm, and ...the seriousness of that harm'.<sup>136</sup> The general defence cannot override the operation of an advance decision<sup>137</sup> or decisions made by a deputy or donee of an LPA within the scope of their authority.<sup>138</sup>

Almost all the provisions in the general defence turn on what D 'reasonably believes'; an objective proportionality criterion is only engaged by acts that amount to restraint. In *ZH v The Commissioner of Police for the Metropolis*<sup>139</sup> the police attempted to rely upon the common law doctrine of necessity to defend a suit brought by a young man with autism under torts of trespass and Articles 3<sup>140</sup>, 5<sup>141</sup> and 8 ECHR. The police had restrained him in a swimming pool where he was on a school trip and locked him in a police van in wet clothes on a cold day, but had not complied with the requirements of the MCA. The court held that 'where the provisions of the Mental Capacity Act apply, the common law defence of necessity has no application'.<sup>142</sup> The judge also held that in order to satisfy the 'reasonable belief' requirements of the MCA it was not necessary to be aware of the Act, or to have it in mind at the time, but a person must 'reasonably believe at the material time ...the facts which determine the applicability of the Mental Capacity Act'.<sup>143</sup>

### 4.3 PRINCIPLES RELATING TO CAPACITY ASSESSMENT

The statutory principles for the assessment of capacity are contained within ss1-3 MCA, and can be summarised as follows:

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<sup>133</sup> s5(4) MCA provides that 'Nothing in this section excludes a person's civil liability for loss or damage, or his criminal liability, resulting from his negligence in doing the act.'

<sup>134</sup> s6(4) MCA

<sup>135</sup> s6(2) MCA

<sup>136</sup> s6(3) MCA

<sup>137</sup> s5(4) MCA; provisions relating to advance decisions found in ss24-6 MCA. See also s4(6)(a) MCA which requires that best interests decision makers must have regard to 'any relevant written statement made by him when he had capacity', which may include advance decisions.

<sup>138</sup> s6(6) MCA – unless action is required to provide a person with life-sustaining treatment or to prevent a serious deterioration in P's condition whilst a decision respecting any relevant issue is sought from the court (s6(7) MCA).

<sup>139</sup> [2012] EWHC 604 (QB)

<sup>140</sup> The right to freedom from torture and inhuman and degrading treatment.

<sup>141</sup> The right to liberty and security of the person

<sup>142</sup> *ZH v The Commissioner of Police for the Metropolis*, [44]. Please note that this case is said to be subject to an appeal (Ruck Keene et al., 2013).

<sup>143</sup> *Ibid*, [40]

- A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.<sup>144</sup>
- A person is not to be treated as unable to make a decision merely because he makes an unwise decision.<sup>145</sup>
- A person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.<sup>146</sup> This impairment or disturbance may be permanent or temporary.<sup>147</sup>
- Incapacity cannot be established merely by reference to a person's age, appearance, a condition of his or an aspect of his behaviour 'which might lead others to make unjustified assumptions about his capacity'.<sup>148</sup>
- A person is unable to make a decision for himself if he is unable–
  - a) to understand the information relevant to the decision
    - i. Including information about the 'reasonably foreseeable consequences' of deciding one way or another, or failing to make the decision.<sup>149</sup>
    - ii. Even though an explanation of it was given to him in a way that is appropriate to his circumstances (using simple language, visual aids or any other means).<sup>150</sup>
  - b) to retain that information,
    - i. but the fact he is able to retain it for a short period only does not prevent him from being regarded as able to make the decision<sup>151</sup>
  - c) to use or weigh that information as part of the process of making the decision, or
  - d) to communicate his decision (whether by talking, using sign language or any other means).<sup>152</sup>

The MCA code of practice, although not the statute, describes a 'two-stage test of capacity' (Lord Chancellor's Office, 2007: 41). Assessors must first ascertain whether or not a person has an impairment or disturbance of the mind or brain (the 'diagnostic' criterion) and then assess whether this impairment or disturbance causes a

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<sup>144</sup> s1(3) MCA

<sup>145</sup> s1(4) MCA

<sup>146</sup> s2(1) MCA

<sup>147</sup> s2(2) MCA

<sup>148</sup> s2(3) MCA

<sup>149</sup> s3(4) MCA

<sup>150</sup> s3(2) MCA

<sup>151</sup> s3(3) MCA

<sup>152</sup> s3(1) MCA – the 'functional' test



person to be unable to understand, retain, use or weigh the information relevant to the decision or communicate it (the 'functional test').

Although functional approaches were felt to be an improvement on tests of capacity that turned on a person's status or the outcome of their decision (Law Commission, 1991: [2.43]), they have been subject to growing criticism. Dhanda (2006-7: 445-6) argues that the process of identifying those who lack capacity 'will render the capacity of all persons with disability open to question'.<sup>153</sup> Lewis (2011: 701-2) writes that functional tests make it 'all too easy for practitioners to attach a label of incompetence to a person with whose decision they disagree'. These translate into republican concerns: firstly, that capacity assessment is in itself an interference that must be subject to clear constraints, and secondly that the assessment process may not adequately constrain the outcomes reached by assessors, leaving people potentially subject to idiosyncratic interpretations and capricious interferences. To consider whether the MCA does constrain when capacity should be assessed and the outcome of that assessment, case law on both these issues will be explored.

#### 4.3.1 CAPACITY ASSESSMENT AS AN INTERFERENCE IN ITSELF

The MCA takes a 'decision-specific' approach to capacity, meaning that a person's mental capacity to make a decision may potentially fall to be assessed across a wide variety of matters affecting them, and repeatedly. Although decision specificity is regarded as one of the more progressive features of the MCA, as in theory it allows a person to retain control over some aspects of their lives even if they lose it in others, it does make heavy demands upon a person to offer themselves up to multiple assessments of their capacity. These assessments do not come 'free'; they represent a significant interference with a person's ordinary rights to privacy and autonomy. Butler-Sloss LJ once stated that a mentally competent person may refuse consent 'for any reason, rational or irrational, or for no reason at all'<sup>154</sup>, yet the process of sorting out the competent from the incompetent necessarily requires a person to offer up their reasons for making a decision to scrutiny.

Morgan and Veitch (2004)<sup>155</sup> have suggested that capacity assessments do not assess a person's ability to make a decision – manifestly the person usually has made a decision, and it its outcome which has triggered the capacity assessment in the first

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<sup>153</sup> A similar point is made by Banner (2012a: 22), who writes that whilst one of the key principles of the MCA is the presumption of capacity, 'in day-to-day practice, it is likely that patients may be routinely assessed for capacity purely in virtue of having a chronic or fluctuating condition that affects their mind or brain.'

<sup>154</sup> *Re MB* [1997] 2 FLR 426 [17]

<sup>155</sup> No page numbers are available for this reference; the quotation was taken from a version that was online (<http://kirra.austlii.edu.au/au/journals/SydLRev/2004/6.html>) but which appears to have been taken down.

place. Instead, they assess ‘whether the person making that decision can construct a convincing case why he or she reaches the standard of the ‘ability’ that law expects in such circumstances’. Sociological, neuroscientific and psychological research suggests that people often make decisions on the basis of emotions and construct post-hoc rationalisations to justify those decisions afterwards (Broome et al., 2012; Damasio, 2008; Gigerenzer, 2008). If this is correct, then some people with reduced verbal fluency and abilities to rationalise may find it harder to convince others of the case for their decision, whilst still making decisions on largely the same – emotional and intuitive – basis as the rest of the population.

Being assessed may be experienced as invasive and disempowering, HH Judge Hazel Marshall (2012) observes:

Consider the implications of taking a test, where you are judged by standards you know nothing of, you have no idea what are or are not the ‘right’ answers, and the result of not passing may well be to have control of your own affairs to destiny removed from you.

Unlike jurisdictions that permit detention in order to conduct an assessment of capacity,<sup>156</sup> a person cannot be compelled to undergo a capacity assessment (Lord Chancellor's Office, 2007: [4.59]). According to HH Judge Hazel Marshall (2012) at least, a refusal to undergo an assessment is not evidence of incapacity, and may even be evidence of capacity. Yet in reality, it seems quite possible that poor co-operation or outright resistance to being assessed could contribute to a finding of incapacity, adding an indirectly coercive dimension to assessment.<sup>157</sup>

Under the MCA the question of when capacity should not be questioned and assessed lies unanswered. Even where a diagnosis of a mental disorder is absent, social care practitioners have been criticised in SCRs for not assessing capacity (Coe, 2010; Flynn, 2011; McAteer, 2010). In *X and Y v Croatia*<sup>158</sup> the ECtHR held that the instigation of formal deprivation of legal capacity proceedings can itself be a significant Article 8 interference, and should be initiated not ‘on the basis of general statements but only on the basis of specific facts’.<sup>159</sup> However, the vast majority of capacity assessments under the MCA are not connected with formal deprivation of legal capacity proceedings,<sup>160</sup> but are decision-specific and connected with the general

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<sup>156</sup> For example, Serbia, Russia, Hungary, Kyrgyzstan and the Czech Republic (Mental Disability Advocacy Centre, 2006; 2007c; a; d; b).

<sup>157</sup> See, for example, the case of *Baker Tilly v Makar* [2013] EWHC 759 (QB).

<sup>158</sup> (App no 5193/09) [2011] ECHR 1835

<sup>159</sup> *X and Y v Croatia*, [107]

<sup>160</sup> The closest domestic analogy to the deprivation of legal capacity proceedings which occur in jurisdictions still operating systems of plenary and partial guardianship is likely to be deputyship under the MCA. Despite the name, guardianship under the MHA is a less apt comparator, as the powers of deputies – especially in relation to financial matters and medical treatment – are potentially far greater and rest on a specific finding of ‘incapacity’.

defence outside of court proceedings. And whilst it seems likely that Article 8 is engaged by assessing a person's capacity, very often that assessment would be in pursuit of one of the legitimate aims by which Article 8 is qualified.<sup>161</sup> The majority of capacity assessments are triggered by some kind of risk or threat to a person's welfare (Emmett et al., 2012; Williams, V. et al., 2012: [2.1]-[2.4]), which might well involve 'the protection of health or morals' or securing to a person other aspects of their ECHR rights. Meanwhile, whilst there are few restrictions on when capacity can be called into question, social care practitioners are coming under growing pressure to assess in a wide variety of situations.

### 4.3.2 WHEN SHOULD CAPACITY BE ASSESSED?

The MCA simply requires that mental capacity be assessed in order to rely upon the general defence; it contains no freestanding obligation to undertake acts that would require the defence. Ironically, although the MCA provides a defence for paternalistic acts, the direction of travel of case law and other interpretations of the MCA is towards capacity assessment becoming a requisite part of a defence for *omissions* to act. In particular, where a person is in danger of making a decision that may result in some harm to them, that danger is known to social care professionals, and there is a possibility that they might lack mental capacity, there is a growing expectation that care workers will assess their capacity and make best interests decisions which could mitigate those risks. This is not, yet, a clear-cut legal obligation, but I suggest that this is only a matter of time. Regardless of whether it is a legal duty or not, the SCRs and LGO reports discussed below suggest that keeping a person's capacity under review is already regarded as part of the role of social services and failure to do so may be maladministration.

#### ASSESSMENT OF CAPACITY ARISING UNDER THE DUTY OF CARE

The 'duty of care' can take on an almost mythological status in social care settings, where it is often invoked to describe any perceived duty – legal or otherwise, lawful or otherwise – connected with caregiving.<sup>162</sup> In strict legal terms, those providing care or other services may have a common law 'duty of care' that requires them to 'take reasonable care to avoid acts or omissions which you can reasonably foresee

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<sup>161</sup> These are: 'the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others' (Article 8 (2)).

<sup>162</sup> Several researchers have found that the 'duty of care' is used to describe paternalistic impulses, and care workers have found it difficult to square with those aspects of the MCA which permit a person to refuse care or take risks (Finlay et al., 2008a; Jingree, Treena and Finlay, 2008; Jingree, Treena, 2009: 86; McDonald et al., 2008: 33; see also Boyle, 2011: 371).

would be likely to injure your neighbour'<sup>163</sup>, yet that duty is not unbounded. For a duty of care to arise, the damage must be foreseeable, there must be a relationship of sufficient proximity between the claimant and defendant, and the court must regard it to be 'fair, just and reasonable' to impose a duty of care in light of policy considerations.<sup>164</sup> In relation to professional negligence, professionals will be held to the standard of a responsible body of opinion within that profession.<sup>165</sup>

In *Re F. (Mental Patient: Sterilisation)* Lord Goff observed that a doctors' duty of care might come into conflict with the torts of trespass:

If they administer the treatment which they believe to be in the patient's best interests, acting with due skill and care, they run the risk of being held guilty of trespass to the person, but if they withhold that treatment, they may be in breach of a duty of care owed to the patient.<sup>166</sup>

The patient's capacity operates as a gatekeeper between these antinomous legal obligations. Where a person has capacity and refuses treatment, the duty of care does not require a doctor to commit trespass; where a person lacks capacity, the tort of trespass does not prevent a doctor giving treatment in accordance with the duty of care. This reasoning was confirmed by the House of Lords in *Tomlinson v Congleton Borough Council & Ors*<sup>167</sup> where Lord Hoffman stated that:

A duty to protect against obvious risks or self-inflicted harm exists only in cases in which there is no genuine and informed choice, or in the case of employees, or some lack of capacity, such as the inability of children to recognise danger (*British Railways Board v Herrington* [1972] AC 877) or the despair of prisoners which may lead them to inflict injury on themselves (*Reeves v Commissioner of Police* [2000] 1 AC 360).<sup>168</sup>

Later cases affirmed that a duty of care to protect against 'obvious risks or self inflicted harm' exists only where there is a lack of 'genuine and informed choice'.<sup>169</sup>

Schwehr (2010: 46) writes that where a relationship of sufficient proximity and a 'voluntary assumption of risk' exists, 'the more incapacitated the person, the more responsibility lies with the authority'. There have not – as yet – been any rulings that have found that social care practitioners were negligent for failing to protect a person who lacked mental capacity from some foreseeable harm which resulted from a choice

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<sup>163</sup> *Donoghue v Stevenson* [1932] AC 562

<sup>164</sup> *Caparo Industries Plc v Dickman* [1990] 2 AC 605; [1990] 2 WLR 358

<sup>165</sup> *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 583. Although, see also *Bolitho (Deceased) v City and Hackney Health Authority* [1998] AC 232, where Lord Browne Wilkinson held that 'if, in a rare case, it can be demonstrated that the professional opinion is not reasonable or responsible' [243].

<sup>166</sup> *Re F. (Mental Patient: Sterilisation)*, Lord Bridge (p1)

<sup>167</sup> [2003] UKHL 47; [2004] 1 AC 46

<sup>168</sup> *Tomlinson v Congleton Borough Council & Ors*, [46]

<sup>169</sup> *Keown v Coventry Healthcare NHS Trust* [2006] EWCA Civ 39; [2006] 1 WLR 953, [12]; *Evans v Kosmar Villa Ltd* [2007] EWCA Civ 1003; [2008] 1 WLR 297 [39]-[41].

that they made.<sup>170</sup> However, it does not seem impossible that such a case could arise. Solicitors have been sued for negligence for failure to detect alleged mental incapacity to litigate when their clients have claimed that this resulted in them accepting disadvantageous compensation settlements.<sup>171</sup> If solicitors can potentially be found negligent for failure to detect mental incapacity and prevent some foreseeable harm to their client, then it seems reasonable to suggest that social care practitioners might also.

#### ASSESSMENT OF CAPACITY ARISING UNDER POSITIVE OBLIGATIONS CONNECTED WITH ECHR RIGHTS

Over the past decades successive ECtHR rulings have imposed upon states positive obligations to take steps to protect individuals' ECHR rights (Mowbray, 2004). These have included obligations under Article 2 to protect against risks to life,<sup>172</sup> and obligations under Article 3 to take 'reasonable steps to prevent ill-treatment of which the authorities had or ought to have had knowledge' of 'children and other vulnerable persons', including ill-treatment by private individuals.<sup>173</sup> In *Dodov v Bulgaria*<sup>174</sup> the ECtHR held that states' duties to regulate public health institutions and their staff, and provide remedies for negligence, were increased 'where patients' capacity to look after themselves is limited'.<sup>175</sup> Nevertheless, the ECtHR has not, as yet, found any positive obligations that directly require a person's mental capacity to be assessed if they wish to commit an act or make a decision which might result in them coming to some harm.

Domestically, under the HRA, the courts have often considered the extent of positive obligations arising under the ECHR through the lens of capacity. In the arena of family law, the courts have found that social workers removing the child of a woman with learning disabilities with her consent violated her Article 8 rights as they had not

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<sup>170</sup> Mandelstam (2009b: [8.12.2]) writes that 'The courts have ... a track record of trying to protect local authorities and the NHS from certain types of negligence case, by holding that the local authority or NHS body did not have a duty of care in the first place. This means that even if there is ostensible carelessness, it is irrelevant because there is effectively no duty of care to breach'. The ruling of the Court of Appeal in *X & Anor v London Borough of Hounslow* [2009] EWCA Civ 286 is a striking example of how restrictively the courts have interpreted a local authority's duty of care in the context of social care.

<sup>171</sup> *Masterman-Lister v Brutton & Co* [2002] EWCA Civ 1889. See also: *Dunhill v Burgin* [2012] EWCA Civ 397, *Dunhill v Burgin* [2011] EWHC 464 (QB), *Dunhill v Burgin* [2012] EWCA Civ 397; (2012) MHLO 33 and the pending 'leapfrog' appeal of that case. The Supreme Court will decide whether a compromise agreement by a 'protected party' (ie. a person who lacks the capacity to litigate) is invalid, if their status as a protected party was not identified at the time.

<sup>172</sup> As established by *Osman v United Kingdom* [2000] 29 EHRR 245

<sup>173</sup> *Z and Others v United Kingdom* (Application No. 29392/95) [2001] ECHR 333; (2002) 34 EHRR 3 [73]. See also *Dorđević v Croatia* on obligations to take action on disability related harassment, *Opuz v. Turkey* (App no 33401/02) [2009] ECHR 870 on failure to prevent serious assaults in situations of domestic violence with the authorities knew about and *E.S. and Others v Slovakia* (App no 8227/04) [2009] ECHR 1282 on failure to properly investigate and prosecute non-consensual sexual acts, including where the victim did not physically resist.

<sup>174</sup> (App no 59548/00) [2008] ECHR 43; (2008) 47 EHRR 41

<sup>175</sup> [81]

considered her consent 'in the light' of the MCA.<sup>176</sup> Hedley J concluded that 'Every social worker obtaining such a consent is under a personal duty (the outcome of which may not be dictated to them by others) to be satisfied that the person giving the consent does not lack the capacity to do so.'<sup>177</sup>

In *Re Z (Local Authority: Duty)*, the case concerning assisted suicide heard under the declaratory jurisdiction<sup>178</sup>, Hedley J found that 'in the context of a person of full capacity, whilst the right to life is engaged, it does not assume primacy ...over rights of autonomy and self-determination'.<sup>179</sup> Hedley J spelled out local authorities' duties to 'investigate the position of a vulnerable adult to consider what was her true position and intention' and to 'consider whether she was legally competent to make and carry out her decision and intention'.<sup>180</sup> In effect, a duty to assess a person's capacity arose out of a local authority's positive obligations under Article 2. Munby LJ interpreted this duty rather more expansively in *A Local Authority v A (A Child) & Anor*<sup>181</sup> as 'a duty at common law to investigate the circumstances of a vulnerable adult whose welfare is seriously threatened by the act of another'.<sup>182</sup> Thus there appears to be a common law duty, arising out of positive obligations under the ECHR, for local authorities to 'investigate' a person's competence if their welfare is threatened by a third party. This common law duty also accords with binding guidance in *No Secrets*, which requires local authorities 'to investigate and take action when a vulnerable adult is believed to be suffering abuse'. This guidance describes a 'vulnerable adult's' capacity as 'the key to action' as 'if someone has 'capacity' and declines assistance this limits the help that he or she may be given' (Department of Health and Home Office, 2000: [1.5], [6.21]).

Although it related to a healthcare setting, the ruling in *Rabone & Anor v Pennine Care NHS Foundation*<sup>183</sup> suggests that the courts may be willing to find an 'operational obligation' to protect a person from self-inflicted harm where there is reason to doubt their capacity. An earlier case had found that Article 2 ECHR imposed an 'operational duty... to take steps to prevent a (detained) patient from committing suicide... if they know or ought to know that there is a real and immediate risk of her doing so'.<sup>184</sup> In *Rabone* the Supreme Court found that a similar operational duty

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<sup>176</sup> *Coventry City Council v C, B, CA and CH* [2012] EWHC 2190 (Fam) [27], [37]

<sup>177</sup> [46]

<sup>178</sup> See above.

<sup>179</sup> *Re Z (Local Authority: Duty)*, [18]

<sup>180</sup> *Re Z (Local Authority: Duty)*, [19]. The proposed Care and Support Bill 2012 would put this duty on a statutory footing. It includes a duty for local authorities to investigate where a person who has needs for care and support 'is experiencing, or is at risk of, abuse or neglect' and 'as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it' (clause 34).

<sup>181</sup> [2010] EWHC 978 (Fam)

<sup>182</sup> *A Local Authority v A (A Child) & Anor*, [65], emphasis mine.

<sup>183</sup> [2012] UKSC 2

<sup>184</sup> *Savage v South Essex Partnership NHS Foundation Trust* [2008] UKHL 74; [2009] 1 A.C. 681 [65]

existed in respect of voluntary patients. Dyson LJ held that the difference between voluntary and detained mental healthy patients was ‘in many ways more apparent than real’, as their ability to ‘make an informed choice to remain in hospital’ may be compromised and they might in any case ‘be detained if she tried to leave’.<sup>185</sup> This was contrasted with the situation of a ‘capable’ patient in a physical healthcare setting,<sup>186</sup> as a psychiatric patient’s ‘capacity to make a rational decision to end her life will be to some degree impaired’.<sup>187</sup> In her judgment, Lady Hale wrote that the operational obligation arose because Melanie Rabone was admitted to hospital with the purpose of preventing her from suicide, ‘Her mental disorder meant that she might well lack the capacity to make an autonomous decision to take her own life’, and the MHA granted hospitals powers to prevent her from leaving where she might do so.<sup>188</sup>

Reasoning by analogy, therefore, it seems arguable that if a person is under the care of the local authority, the purpose of that care is to prevent some ‘real and immediate risk’ which the authority knows or ought to know about, and the person lacks the mental capacity to make decisions about that risk, an obligation arises to use the MCA to protect them from that risk. Barristers for the Rabone family have argued that this operational obligation could be owed to ‘any vulnerable person for whom any public authority has assumed responsibility, whether they were in hospital or not’ (Solicitors Journal, 2012). The potential for operational obligations to arise for local authorities is, however, uncertain. It may depend on what being ‘under the care’ of the local authority means – does it mean merely that they have assessed a person, that they directly provide services for that person, or that the person is in local authority arranged residential care? Does the obligation arise for the local authority, or the care provider, especially given that not all care providers must have regard for the ECHR because of the HRA<sup>189</sup>?

Whether or not a broad reading of positive obligations arising from the ECHR is sustained in court, a number of reports by the LGO and SCRs have given them a very expansive gloss.<sup>190</sup> Several published reports by the LGO and the Parliamentary and Health Services Ombudsman (PHSO) also detailed deaths or serious illnesses or injuries which the ombudsmen linked to a lack of capacity on the part of a person to understand their care needs. For example, the LGO was critical of care staff who failed to open windows and prevent a woman with dementia from overdressing and over-

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<sup>185</sup> [28]

<sup>186</sup> [28]

<sup>187</sup> [30]

<sup>188</sup> [105]

<sup>189</sup> Following the ruling in *YL v Birmingham City Council*, discussed in Chapter 2 in the section entitled ‘From colonies and control, to care in the community’.

<sup>190</sup> Summaries of LGO reports which reference capacity are described in more detail in Appendix B.

exercising in hot weather, resulting in a hospital admission. Care staff had told investigators that the woman's wishes had to be taken into account, and the LGO found maladministration on the part of the local authority for failing to carry out risk assessments and communicating 'to care workers the limits of Mrs Nash's capacity'.<sup>191</sup> In another case a woman alleged that her brother, who had a history of detention under the MHA, had 'lived in squalor and pain'. A nursing advisor for the Ombudsmen criticised care workers and the community mental health team for cultures that emphasised a person's 'right to live in the way they chose' (Parliamentary and Health Service Ombudsman and Local Government Association, 2011). More details of these and other similar cases relating to capacity are given in Appendix B.

Although they are not a source of legal authority, SCR's offer insights into how social services authorities understand and interpret their professional roles. In a recent SCR into the murder of 'Adult A', Flynn (2011: 12.23) writes

...whilst the Mental Capacity Act 2005... presumes individuals to have capacity, this does not and should not mean that professionals are exempt from asking challenging and searching questions in relation to individuals who are making problematic choices. The presumption of capacity does not exempt authorities and services from undertaking robust assessments where a person's apparent decision is manifestly contrary to his wellbeing.

Similar themes resonate in other SCRs (e.g. Bardsley, 2009; Coe, 2010; Flynn, 2007; McAteer, 2010). The legal source of obligations to 'ask challenging and searching questions' about a person's capacity to make problematic choices is not spelled out in these SCRs. It may be thought to originate from local authorities' obligations under the ECHR and HRA 'to take reasonable steps to safeguard individuals from abuse or life threatening events is in breach of Articles 2 and 3' ECHR (Flynn, 2011: 12.25). As noted, this has not (yet) been firmly established in case law, but it seems reasonable to expect that the courts might make such a ruling in the future, especially if social care professionals are acting under the belief that such obligations already exist.

## DISCUSSION

The expectation that social care practitioners will be alert to 'problematic choices' and 'ask challenging and searching questions' about the capacity of people with mental disabilities may contribute to the 'constant sanctioning interaction from above' identified by Goffman (1961: 43). As one advocate<sup>192</sup> who worked with people with learning disabilities who was interviewed for this research put it:

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<sup>191</sup> *Worcestershire County Council* 2011 (09/013/172)

<sup>192</sup> This advocate was not an IMCA.



How many people with learning disabilities can just walk out the door without somebody monitoring what they're up to... how often can they just go, wherever they want to go, whenever they want to go? Go on holiday wherever they want to go, live wherever they want to live... Have sex whenever they want to have sex? You know, anything that they want to do? ... The system has to be shown to be protecting them, but to protect them, their freedoms will be impinged so that the system will be shown to have made sure that they're not going to get themselves in trouble.<sup>193</sup>

As discussed in Chapter 2, republicans tolerate interferences, even quite considerable interferences, so long as they are directed towards ameliorating domination and do not create new forms of domination themselves. From a republican perspective, much will depend on how far the arbitrariness of capacity assessments themselves are constrained. If, as Kapp (2002) has suggested, capacity assessments can be vague and arbitrary, then there are reasons to believe that protective interventions premised upon incapacity are in danger of delivering people to new forms of domination.

### 4.3.3 HOW SHOULD MENTAL CAPACITY BE ASSESSED?

The outcomes of capacity assessments are potentially sensitive to a range of factors in how they are conducted and interpreted. This introduces a risk of arbitrariness unless these factors are suitably constrained. This section considers several factors that may well affect outcomes, and discusses whether or not they are suitably constrained by the common law. At base, the criticism of capacity assessments in this section is that although the MCA was explicitly designed to be 'functional', driven by processes not outcomes (Law Commission, 1991: [2.43]-[2.44]), the case law viewed as a whole does not reflect this. Instead, it looks as if outcomes do heavily influence courts' determinations of whether or not a person has mental capacity, even when very similar processes appear to be at work. Because this is not explicitly acknowledged, the principles guiding decisions are not clearly articulated. This leaves assessors with tremendous scope to pick and choose elements of decisions that support the outcomes they prefer. That is to say, the arbitrariness of capacity assessments is fostered by the rulings, not constrained.

### WHO SHOULD ASSESS CAPACITY?

For all the efforts to define capacity in individualistic and 'cognitive' terms (e.g. Appelbaum and Grisso, 1988; Cairns et al., 2005; Grisso and Appelbaum, 1995; 1997; Sullivan, 2004; Palmer et al., 2004; Centre for Disability Law & Policy, 2011), at base assessment 'must be recognised as a personal encounter between two people'

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<sup>193</sup> 'Lara', advocacy worker, Cornwall.

(Donnelly, 2009b: 477-8). Stefan (1992-1993: 766-7) describes competence<sup>194</sup> as ‘a value judgment arising from an individual's conversation or communication with individuals in positions of power or authority’. She argues that competence is all too often regarded as an internal characteristic when in fact it may simply reflect a failure of communication.

The social and interpersonal dimensions to capacity assessment means that it very much matters who conducts them. Baggs (2011) has described her frustration at being judged incapable by a person who barely knew her, and how her resultant anger at this appraisal was used as further evidence of her incapability. Yet the MCA requires any person who wishes to rely upon the general defence for some act of care or treatment to assess it, without regard to the quality of their relationship with the person. Assessors are constructed by the Act as fungible entities, as if - to borrow from Foucault (2001/1961: 239) – the only authority an assessor needs is ‘the authority that is his for not being mad’. By offering few tools to respond to the varying quality of relationships between assessor and assessed, the MCA may not be able to constrain any arbitrariness of outcome which results from this factor.

Research on mental capacity and best interests decision making processes in health and social care found that decisions tended to be made jointly, as part of a team, rather than through identifying a sole decision maker with overall responsibility. Williams, V., et al (2012: [4.2]) argue that greater clarity is needed in the code of practice over who is responsible for making decisions. For certain kinds of decisions about capacity – chiefly those taken within the formal confines of the Court of Protection’s declaratory powers<sup>195</sup> and capacity assessments under the DoLS – it will be straightforward to identify a single capacity assessor.

Yet the vast majority of decisions in care are not made under these formalised structures; any person who might potentially need to rely upon the general defence will need to have complied with the capacity assessment and best interests requirements of ss1-6 MCA. As the public authorities listed as defendants in the smattering of cases where the general defence has been invoked demonstrates, it may not necessarily be a ‘natural person’ who relies upon the general defence.<sup>196</sup> In such circumstances, and where multiple organisations work to arrange and deliver care in tandem, it is easy to see how the identity of which individual is responsible for assessing capacity can become uncertain. The answer is likely to be fact specific, and related to the seniority, professional status and level of participation in the relevant act of the various

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<sup>194</sup> This is the term used by Stefan herself, but she uses it to mean a concept essentially analogous to ‘mental capacity’.

<sup>195</sup> s15 MCA

<sup>196</sup> *G v E, A Local Authority & F* [2010] EWHC 621 (Fam); *London Borough of Hillingdon v Neary & Anor* [2011] EWHC 1377 (COP); *C v A Local Authority* [2011] EWHC 1539 (Admin); *R (Sessay) v South London & Maudsley NHS Foundation Trust & Anor* [2011] EWHC 2617 (QB).

individuals involved. The courts have even criticised local authorities for care providers' failure to consider the mental capacity and best interests of people whose rights were infringed.<sup>197</sup>

Although legally the responsibility for assessing mental capacity lies with those directly associated with a particular act of care or treatment, they may seek guidance from third parties. The MCA code of practice endorses obtaining a professional opinion from a medical or social work professional for 'more complex decisions' (Lord Chancellor's Office, 2007: [4.42]). Application forms for the Court of Protection require evidence of incapacity to be completed by 'a registered medical practitioner, psychologist or psychiatrist' or in some cases a speech therapist, occupational therapist or similar (Court of Protection, undated). However, except where a case concerns deprivation of liberty,<sup>198</sup> neither case law nor statute imposes any requirements for a 'clinical' or medical assessment. Recent domestic<sup>199</sup> and ECtHR<sup>200</sup> rulings have reiterated that in formal deprivation of legal capacity proceedings it is for the judge – not a doctor – to make a final assessment of capacity. Nevertheless, the 'medicalisation' – or at least 'professionalisation' – of capacity assessment appears to have been a deliberate result of including a diagnostic threshold in the functional test (Law Commission, 1991: [3.11]).

The medicalisation of mental capacity brings mixed blessings. On the one hand, clinical assessments appear to have strong inter-rater reliability (Cairns et al., 2011a; Okai et al., 2007), which seems desirable from the perspective of reducing arbitrariness. On the other, these assessment tools are calibrated 'by the judgement of an expert clinician, not a perspective-neutral measure of psychological functioning' (Banner, 2012b: 1040). They risk imposing a medicalised model of capacity that sits in tension with supported decision making models of legal capacity inspired by the social model of disability and Article 12 CRPD. A preference for 'professional' assessments reinforces concerns, outlined in Chapter 2, that law cannot act as an effective restraint against disciplinary power and becomes colonised by disciplinary discourses and norms. Despite a veneer of scientific respectability and objectivity, mental capacity assessments measure phenomena 'of a moral and social order' (Foucault, 2001/1961:

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<sup>197</sup> *City of Sunderland v MM & Ors* [2009] CoPLR Con Vol 881

<sup>198</sup> See *Winterwerp v the Netherlands* (App no 6301/73) (1979) 2 EHRR 387; *G v E & Ors* [2010] EWCA Civ 822.

<sup>199</sup> In *A County Council v K, D and L* [2005] EWHC 144 (Fam); [2005] 1 FLR 851 [39], Charles J stated that 'the roles of the court and the expert are distinct', and that it was for the court to 'weigh the expert evidence against its findings on the other evidence' – including the perspectives of non-experts on capacity, and the judge's own view formed from oral evidence from the subject of the proceedings. Reiterated by Baker J in *CC v KK and STCC* [2012] EWHC 2136 (COP) [24].

<sup>200</sup> *X and Y v Croatia*, [85]

258), which have an inherently normative dimension (Banner, 2012b; Charland, 2001; Freyenhagen, 2009; 2013; Holroyd, 2010).

It would be unfair, however, to suggest that the courts only ever act as a rubber stamp on professional opinion. The courts have, for example, criticised reliance on psychometric tests<sup>201</sup> and a lack of expert knowledge of the MCA itself.<sup>202</sup> Most strikingly, in *CC v KK and STCC Baker J* concluded that a person had mental capacity, even though both experts and a social worker were unanimous that she did not. It is unusual, however, to see the courts take such a muscular approach to capacity assessment, prying into the black box of clinical judgment, but nevertheless this case shows that it can happen.

It has sometimes been suggested that those with personal knowledge – rather than ‘professional’ knowledge – might be better situated to understand a person’s communication and intentions (Bach and Kerzner, 2010). This approach would appear to favour the involvement of family carers in divining capacity over disciplinary professionals. Yet there is little in the disability rights literature to suggest that families are a preferable source of authority over disabled people to professionals – the target is authority itself. Capacity assessment unavoidably involves affording an assessor group power and authority over the assessed; republicanism offers no clear answers over who that group should be, it simply suggests that the way they exercise that power should be suitably constrained.

## SUPPORTS FOR CAPACITY

A central requirement of Article 12 CRPD is that state parties provide access to the support people ‘may require in exercising their legal capacity’. This is generally interpreted to mean that people must be given the support they need to make (legally salient) decisions. The MCA states that ‘A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success’.<sup>203</sup> Later provisions emphasise that a person should be given support to understand the information relevant to the decision ‘in a way that is appropriate to his circumstances’.<sup>204</sup> The role of support in decision making raises a number of complex and profound legal and metaphysical questions, not all of which can be addressed in any great detail here. Regarding the CRPD, one important question is whether support will always be sufficient to enable a person to make a decision, as some seem to suggest (Dhanda, 2006-7; Inclusion Europe, 2008; International Disability Alliance, undated; Minkowitz, 2006-7; World Network of Users and Survivors

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<sup>201</sup> *Verlander v Rahman* [2012] EWHC 1026 (QB); (2012) MHLO 49 [51]

<sup>202</sup> *SC v BS* [2012] MHLO 78 (COP)

<sup>203</sup> s1(3) MCA

<sup>204</sup> s3(2) MCA

of Psychiatry, 2011a), or whether there are a residue of cases where 'substituted decisions' remain necessary.<sup>205</sup> A second dimension of these debates is the extent to which Article 12 permits forms of support and substituted decisions that conflict with a person's expressed wishes and preferences.<sup>206</sup>

These debates are extremely important, but they are not explored in any great detail here. The MCA makes provision for support only up to a point; a person must still be able to satisfy the 'functional test' or else a substituted decision will be made in their best interests. Consequently, the following questions are relevant when considering support arrangements under the MCA:

1. What forms might 'support' take?
2. At what point does a person require so much support to make a decision (or decisions), that they are no longer regarded as making a capacitous decision for themselves?
3. What distinguishes support from a third party for making a decision from 'undue influence', which may mean they lack the mental capacity to make that decision?
4. Might support ever be provided that conflicts with a person's wishes and preferences, and thus may be regarded as an interference in itself?

Clear and consistent answers to those questions will be essential for constraining the potential for arbitrary and idiosyncratic assessments regarding support arrangements and capacity.

The MCA itself gives no examples of what forms support might take beyond ensuring information is provided to a person by the most appropriate means possible. The code of practice provides some practical suggestions for addressing a person's communication needs, including the provision of communication equipment, time to learn new communication systems, or specialist professional support (Lord Chancellor's Office, 2007: [3.11]). Regarding retention of information, the code suggests that 'Items such as notebooks, photographs, posters, videos and voice recorders can help people record and retain information' [4.20]. An example of support for mental capacity from case law includes providing a person with sex education so

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<sup>205</sup> See Quinn (2010), Booth Glen (2012) and Bach and Kerzner (2010) for suggestions on how Article 12 CRPD might accommodate cases where a person's will and preferences in relation to a decision are not discernible.

<sup>206</sup> This seems unlikely, in light of Article 12(4), which states that safeguards must ensure that 'measures relating to the exercise of legal capacity respect the rights, will and preferences of the person'.

that they might understand the requisite information for the capacity to consent to sex.<sup>207</sup>

Some of the literature on Article 12 CRPD appears to endorse much more involvement of third parties than merely providing a person with accessible information and memory aids. This is best encapsulated by Francis and Silvers' (2010) proposed model of 'assistive thinking', in which the support provided by 'trustees' to help people make decisions is likened to a 'prosthetic' (see also Silvers, 2011; Silvers and Francis, 2009). In support of such arrangements it is often emphasised that all people rely on others when making important decisions (European Disability Forum, 2009; Lewis, 2011; Quinn, 2012), that the individualistic models of autonomous decision making are 'sociologically counterfactual' (Lewis, 2011: 703). There is some empirical support for the idea that our decision making abilities are contingent upon good quality relationships of trust (Broome et al., 2012).

Relationships of support to facilitate decision making are not well researched under the MCA. Boyle (2008b: 534) writes that in terms of implementation, the MCA's 'provisions for support are insufficient for promoting self-determination'. However, there is some evidence that sometimes the involvement of an IMCA can help a person to attain the threshold of mental capacity (Townesley & Laing, 2011; Williams, V. et al, 2010). The case law associated with the MCA has taken some tentative steps towards recognising such 'relational' elements of decision making, but the courts have not developed a clear and consistent way of distinguishing *support for* capacity from *evidence of* incapacity, and in some instances the influence of third parties on decision making is taken to *deplete* capacity.

The case *V v R*<sup>208</sup> offers the strongest support yet for recognising 'relational' elements of capacity. The court considered whether V, a young woman who had suffered brain damage after being hit by a car, had the capacity to litigate for compensation proceedings. V's mother gave the following evidence regarding V's reliance upon her to make decisions about the court case:

I have been asked to think about what V would do if she was asked by her solicitor to make a decision in the case and I was not available to advise her. I believe that V would just agree to whatever was being proposed or had been advised. She doesn't question or analyse issues or advice herself and, as discussed in a number of the medical reports, often acts impulsively.<sup>209</sup>

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<sup>207</sup> *D Borough Council v AB* [2011] EWHC 101 (COP); *A Local Authority v H* [2012] EWHC 49 (COP)

<sup>208</sup> [2011] EWHC 822 (QB)

<sup>209</sup> *V v R*, [28]

According to V's mother, 'she and not the claimant would make any material decision.'<sup>210</sup> The court, observing that there was no suggestion that V would be left to make decisions without the support of her mother, concluded that it was 'not satisfied, on the balance of probabilities, that the claimant is unable to use and weigh information as part of the process of making litigation decisions'.<sup>211</sup>

In holding that V had litigation capacity, the court appeared to strongly endorse the kinds of support arrangements Francis and Silvers and others had in mind. However, a later judgment - *Verlander v Rahman*<sup>212</sup> - raised analogous issues yet the court came to the opposite conclusion regarding a person's financial capacity:

On the basis of the above information it cannot properly be said that the Claimant is managing her own money. She is only doing that, and making decisions in relation to it, with the substantial assistance of her mother. Even if it were to be the case that she participates in the decision to pay individual bills and then carries that out and obtains the receipts, the guiding person in making the decision is her mother.<sup>213</sup>

Unhappily *Verlander v Rahman* made no reference to the decision in *V v R* to enable us to distinguish the reasoning in these cases. The processes and support arrangements for capacity in both cases appear to be the same, but the issues could be distinguished in terms of outcomes. In *V v R* any decisions about litigation would go through V's solicitor, who would be able to flag up any concerns to the court. However, there would be few such checks to prevent *Verlander* spending her money unwisely. Without clearly articulating why support can enhance V's litigation capacity, yet is evidence of *Verlander*'s financial incapacity, it is hard to avoid the view that the different treatment of support in these two cases is predicated on outcomes and not processes.

In *V v R* the outcome of V's decisions around litigation appear to be almost entirely determined by her mother's views, rather than V's own. In *V v R* the court appeared to regard this as a positive and supportive arrangement, but other cases exist where the influence of a third party over a person's decision making is held to *deplete* capacity, and is often described as 'undue influence'. Under the declaratory jurisdiction the courts considered whether various decisions were invalid as a result of

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<sup>210</sup> *V v R*, [29]

<sup>211</sup> *V v R* [35]

<sup>212</sup> [2012] EWHC 1026 (QB) [94]. It seems likely – given the similarity of the facts, and the identical expert witnesses in the judgment, that the judgments *V v R* and *Verlander v Rahman* relate to the same case – although this is nowhere stated in the judgments or elsewhere in the public domain. I will continue to refer to the plaintiffs as V and *Verlander* to make clear which judgment I am describing, although they may well be one and the same person.

<sup>213</sup> *Verlander v Rahman*, [94]

'undue influence', including medical treatment decisions,<sup>214</sup> the execution of a will,<sup>215</sup> the posthumous destruction of a man's frozen sperm,<sup>216</sup> and the capacity to consent to marriage.<sup>217</sup> Subsequent to the passing of the MCA, the courts have continued to hear cases regarding 'undue influence' even where people are said to have 'mental capacity' under the inherent jurisdiction.<sup>218</sup> Under the MCA, several interesting cases have arisen where the influence of a parent is thought to be stifling the development of a person's independent decision making abilities. In these cases, the courts have sanctioned significant interventions to *disrupt* these relationships, on the basis that this interference will *enhance* a person's capacity.

In *A Primary Care Trust v P*<sup>219</sup> the Hedley J found that P lacked the mental capacity to decide whether or not to remain living with his mother as a result of the 'cumulative force' of his epilepsy, his learning disability, and:

...the enmeshed relationship that he has with AH which severely restricts his perspective in terms of being able to think about his future... his inability... to visualise any prospect of having a different view to his mother on any subject that matters and his inability to understand what the other aspects of the argument may be in relation to his expressed wishes simply to return and live undisturbed with his mother.<sup>220</sup>

There were additional concerns that P's mother had interfered with the medication regime for his epilepsy in the belief that it was causing Chronic Fatigue Syndrome. Cessation of his medication had resulted in increased seizures and an emergency hospital admission for P. Hedley J approved care arrangements which amounted to a deprivation of liberty and carried significant constraints on his contact with his mother, despite it being P's wish to remain living with her.<sup>221</sup> It was hoped that 'by prising him out of his current relationship, significantly curtailing contact and thereby allowing space for the development of a new experience' P would regain capacity to make decisions.<sup>222</sup>

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<sup>214</sup> *Re T (adult: refusal of medical treatment)*

<sup>215</sup> *Wilkes v Wilkes* [2006] WTLR 1097

<sup>216</sup> *Centre for Reproductive Medicine v U* [1993] Fam 95

<sup>217</sup> *SA (Vulnerable Adult with Capacity: Marriage)* [2005] EWHC 2942 (Fam); [2006] 1 FLR 867

[6]

<sup>218</sup> *DL v A Local Authority & Ors* [2012] EWCA Civ 253; *Re G* [2012] EWCA Civ 431; (2012) MHLO 52. These cases were heard under the 'inherent jurisdiction' as they would not engage the statutory jurisdiction of the Court of Protection as the relevant person did not 'lack capacity' in the meaning of the Act. The inherent jurisdiction is not considered extensively in this thesis, but several useful discussions are available (Herring, 2009; Lord Justice Munby, 2011; Sofaer, 2012; Szerletics, 2011).

<sup>219</sup> [2009] EW Misc 10 (EWCOP).

<sup>220</sup> *A Primary Care Trust v P & Ors*, [37]

<sup>221</sup> [42] The restrictions on contact are discussed below.

<sup>222</sup> [57]



In the important Court of Appeal ruling in *K v LBX*<sup>223</sup>, it was common ground that L lacked the mental capacity to decide whether or not to continue living with his father and brother, or whether to move into ‘independent living’ accommodation.<sup>224</sup> K was said to be happy living with his father and brother,<sup>225</sup> but professionals expressed concern ‘that L was in an environment in which he could not articulate his own wishes, as opposed to what he perceived to be the wishes of his father.’<sup>226</sup> Part of the High Court’s decision that it would be beneficial for him to leave home was a belief that it ‘would enable him to either regain capacity, or enable him to make informed choices and decisions’.<sup>227</sup>

Relationality is thus a complex area of capacity assessment. On the one hand, the courts have regarded the support a person receives from a third party as contributing to capacity. Yet in other cases, reliance on support is regarded as evidence of incapacity. In yet further cases, the courts have taken steps to remove a person from a relationship where the influence of a third party is regarded as *depleting* capacity – even when the person concerned expresses no desire to be so removed. To return to our questions at the outset, the courts have delivered conflicting decisions regarding when support enhances mental capacity and when it is evidence of mental incapacity. The courts do appear to be treating certain relational dependencies as *depleting* capacity – more akin to undue influence than support arrangements – but have not articulated any clear principles to distinguish dependency that amounts to undue influence from that which amounts to support. And finally, the courts have been prepared to sanction major interventions in a person’s relationships and living arrangements for the improvement of a person’s mental capacity. Without clear criteria to help distinguish ‘support’ from ‘undue influence’, there is a danger that those making such decisions – including professionals as well as the courts – may import a dislike or suspicion about a third party into their assessments of capacity on an arbitrary basis.

These cases also have important implications for the support paradigm endorsed by the CRPD. In their writings on ‘assistive thinking’, Francis and Silvers have little to say about the possibility of ‘undue influence’ from supporters. A core requirement of Article 12(4) CRPD is that measures that relate to the exercise of legal capacity are free of undue influence; yet there is little in the CRPD to help us identify what ‘undue influence’ looks like in situations like this. Remarkably, the literature

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<sup>223</sup> [2012] EWCA Civ 79

<sup>224</sup> [16]

<sup>225</sup> [8]

<sup>226</sup> [7]

<sup>227</sup> Paragraph 54. Unfortunately, the High Court ruling in *K v LBX* has not (to date) been published, and the ruling of the Court of Appeal is somewhat ambiguous regarding L’s own preferences.

related to Article 12 which is most enthusiastic about relational autonomy, 'shared personhood' and supported decision making does not explore this issue (e.g. Bach and Kerzner, 2010; Centre for Disability Law & Policy, 2011; Dhanda, 2006-7; Lewis, 2011). These judgments, however, do suggest that there are sometimes grounds to be concerned that support itself may become a form of domination.

### WHAT NEEDS TO BE UNDERSTOOD?

As the information relevant to the decision will be highly context specific, the MCA does not define precisely what information needs to be understood for the purposes of the functional test of capacity.<sup>228</sup> Macur J cautioned in *LBL v RYJ*<sup>229</sup> that 'it is not necessary for the person to comprehend every detail of the issue' and 'all peripheral detail' so long as they can 'comprehend and weigh the salient details relevant to the decision to be made'. However, given that capacity assessors might enjoy considerable latitude in setting the parameters of what needs to be understood, this is an area with clear potential for arbitrary decisions that will affect the outcome of capacity assessments.

In a large ethnographic study about the capacity of dementia patients to make hospital discharge decisions about their care and residence, Emmett et al (2012) found worrying evidence that capacity assessments often focussed on a person's general awareness levels, not whether or not they understood the information relevant to the particular decision. They found examples of people's mental capacity regarding whether or not to move into a nursing home being 'assessed' without assessors ever explicitly discussing such a move with them. Assessors would also make reference to a person's failure to appreciate information that was not obviously relevant to the decision in hand. Emmett suggests that it may be especially difficult to provide clarity over what risks and other matters a person needs to understand for decisions about care and residence, where the nature of the risks may be less clear and predictable than in healthcare decisions.

These issues arose in the case *CC v KK & STCC*. The case arose under the DoLS, and took the form of a challenge by KK to assessments which had found that she lacked the capacity to decide to leave the care home, where she was unhappy, or to return to live in her bungalow.<sup>230</sup> Assessors had asked KK to describe the options as

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<sup>228</sup> See s3(4) MCA

<sup>229</sup> [2010] EWHC 2664 (Fam) [24], [58]. Reiterated by Baker J in *CC v KK and STCC*, [22].

<sup>230</sup> To the best of my knowledge, this may be the first (published) case brought under the MCA where 'P' has used the Court of Protection to challenge a capacity assessment which he disagrees with. Of course the court has considered the question of a person's capacity on ample occasions, especially where there is some dispute over treatment or suchlike, or there is doubt over the appropriate test to be supplied. However, this appears to be the first time that P has actively used the court to contest an assessment, as opposed to concerned third parties coming to court seeking confirmation of questions regarding P's capacity. If I am correct, it is

she understood them, but at no point had the local authority provided any information as to what support would in fact be available to KK if she were to return home. Consequently, capacity assessors had concluded she was unrealistic about the risks of a return home, and the resources available to mitigate those risks; yet neither they nor she knew what support would in practice be available. Baker J criticised assessors for basing capacity assessments on a 'blank canvass' of what KK already knew.<sup>231</sup> According to Baker J, supporting a person to make a decision requires that they are provided with information about the options, and associated support and risks,<sup>232</sup> and are not to be expected to generate this information themselves. Baker J stated that KK should have been provided with details of the 'complete package of support that would or might be available' for a return home in order to assess her capacity.

This guidance seems eminently sensible, yet it may be a challenge to reconcile with community care law. Public law rulings suggest that local authorities are not obliged to generate alternative offers of support if they believe they cannot meet a person's eligible community care needs or if they exceed the cost of meeting their needs in other ways.<sup>233</sup> This means that assessing a person's mental capacity to choose between institutional care and some alternative, typically a return home, will be problematic if local authorities believe that a person's assessed eligible needs can only be met (or be met most economically) in an institutional setting. The interface between care planning and a person's capacity to assume the risks of a care plan which local authorities regard as inadequate needs further attention.

In cases about the capacity to consent to sex and marriage, the courts have tried not to set the test of capacity too high 'lest it operate as an unfair, unnecessary and indeed discriminatory bar against the mentally disabled.'<sup>234</sup> Yet, if the bar is set too low, local authorities and courts cannot use the MCA to intervene in sexual relationships that give them cause for concern. These tensions have played out in a debate about whether the requisite capacity to consent to sex and marriage requires understanding of issues around the partner in the relationship ('person-specific' mental capacity) or is generic to the act ('act-specific' mental capacity). Person specificity gives public authorities greater flexibility to intervene in particular relationships where they have cause for concern, whilst allowing acceptable relationships to continue. Several judges have expressed discomfort with the idea of the state exercising this

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remarkable that it took until 2012 for the first 'appeal' against a capacity assessment to be heard. Possible reasons for this will be considered in Chapters 5 and 6.

<sup>231</sup> [38]

<sup>232</sup> [68]

<sup>233</sup> *Khana v London Borough Of Southwark* [2001] EWCA Civ 999

<sup>234</sup> Munby LJ in *Sheffield City Council v E & Anor* [2004] EWHC 2808 (Fam) [144]

level of control over a person's private life. In *Sheffield City Council v E & Anor*<sup>235</sup> Munby J asked:

Can it seriously be suggested that the court has the right to vet E's suitors, to decide that X is suitable but that Y is unsuitable, to select who E is to marry? The answer to that question, in my judgment, is that the court quite clearly has no such role.<sup>236</sup>

At the time of writing the test of mental capacity to consent to marriage was considered act-specific and not person-specific,<sup>237</sup> but the test of mental capacity to consent to sex is still somewhat unsettled (Richards, 2012). The most recent case, *A Local Authority v H*, affirmed the 'act specific' approach taken in *D Borough Council v AB* and other cases<sup>238</sup> – but these in turn conflicted with *D County Council v LS*.<sup>239</sup>

The mental capacity to make decisions about contact with friends and family members has also been held to have person-specific elements.<sup>240</sup> In *CYC v PC and NC*<sup>241</sup> Hedley J considered the capacity of a woman with mild learning disabilities to decide whether to resume married life. Her husband's sentence for criminal offences against his previous wives was shortly due to expire. The woman, PC, did not accept her husband's guilt, and an expert assessor concluded that 'Given her learning disability, her unwillingness to examine the issue of his guilt and her overwhelming desire to re-establish that relationship'.<sup>242</sup> Hedley J expressed concern that the assessment had not separated out PC making an unwise decision from incapacity,<sup>243</sup> but independently he concluded that PC was unable to understand the risks NC posed to her or weight them up.<sup>244</sup> Hedley J eschewed the debate on whether or not capacity was person- or decision-specific, saying that it would depend upon the specifics of the case.<sup>245</sup>

In these concerns around person and act specificity, the courts very explicitly consider the impact of the way capacity is framed upon the relationship between individuals and their private lives, and the state. Far from being an internal, neutral,

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<sup>235</sup> Ibid.

<sup>236</sup> *Sheffield County Council v E*, [91]. See also *D Borough Council v AB*, [35], where Mostyn J asked 'Is the local authority supposed to vet every proposed sexual partner of Alan to gauge if Alan has the capacity to consent to sex with him or her?'

<sup>237</sup> *Sheffield County Council v E*

<sup>238</sup> *X City Council v MB, NB and MAB* [2006] EWHC 168 (Fam), [2006] 2 FLR 968 and *Local Authority X v MM and KM* [2007] EWHC 2003 (Fam).

<sup>239</sup> [2010] EWHC 1544. See also *R v C* [2009] UKHL 42; [2009] 1 WLR 1786 where the House of Lords considered the capacity to consent to sex in the context of the Sexual Offences Act 2003.

<sup>240</sup> *Re MW; LB Hammersmith and Fulham v MW* (Case no 11620762) [2012] MHLO 82 (COP)

<sup>241</sup> [2012] MHLO 103 (COP). This case is said to be subject to an appeal (39 Essex St Court of Protection Newsletter, January 2013)

<sup>242</sup> [12]

<sup>243</sup> [12]

<sup>244</sup> [21]

<sup>245</sup> [20]

construct – capacity in these debates is very clearly political. They also reflect a wider tension around the way mental capacity is defined, between reasonably clear and narrow principles which (in this case) set thresholds low – reducing the possibilities for paternalistic intervention – or broader, more flexible, criteria which can be applied in a wider range of situations, but which increase the risk of arbitrary interventions.

#### ‘INSIGHT’ AND UNWISE DECISIONS

Several commentators have remarked on the potential for doctors to find that patients lack mental capacity on grounds that they lack ‘insight’ into their condition (Allen, 2009; Banner, Natalie F., 2012b; Holroyd, 2010; Szasz, 2005). Allen (2009) cites Munby LJ as endorsing the position that capacity requires insight:

If one does not ‘believe’ a particular piece of information then one does not, in truth, ‘comprehend’ or ‘understand’ it, nor can it be said that one is able to ‘use’ or ‘weigh’ it. In other words, the specific requirement of belief is subsumed in the more general requirements of understanding and of ability to use and weigh information.<sup>246</sup>

One might foresee problems arising where people simply do not share their doctor’s view of their diagnosis and treatment options, or a social care professional’s assessment of their care needs and the value of a particular care plan.

Empirical studies in health and social care suggest that capacity assessors are, indeed, influenced by how far person agrees – or has ‘insight into’ – their assessment of their needs. Owen et al (2009) conducted a study of patients’ mental capacity to consent to psychiatric admission, and analysed associations with their diagnosis and ‘insight’ into their condition. They found that psychotic disorders and manic episodes of bipolar affective disorder were highly associated with both incapacity and lack of insight, but in patients with non-psychotic disorders such as depression, incapacity could exist alongside insight into their condition. However, a study by Elbogen et al (2006) found that psychiatrists place greater value on ‘insight’ than other psychologists and social workers, who were more likely to endorse respect for autonomy.

In social care settings, Williams, V., et al (2012: 6, 123) found evidence that sometimes ‘lack of capacity equated to the fact that a person could not understand or admit to their own care needs.’ The authors recommended that the MCA code of practice be updated to provide guidance on ‘The distinction between “lack of insight” into one’s own care needs, and lack of decision making capacity’ (p17). In their study of hospital discharge decisions, Emmett et al (2012: 5) found that ‘Where assessors did not agree with patients’ decisions, they were prone to interpret the decision as lacking insight and, thus, the decision maker as lacking capacity.’

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<sup>246</sup> *Local Authority X v MM and KM*, [81]

There is a danger that a lack of insight into a person's care needs is conflated with a person being prepared to tolerate the risks of unmet needs. *CC v KK*, discussed above, was one such case. Assessors felt that KK did not recognise the risks attached to a return home,<sup>247</sup> or if she did she understood them only 'superficially'<sup>248</sup> and was not able 'able to hold complex concepts in her mind in order to weigh risks and benefits and to make informed choices regarding her future.'<sup>249</sup> The 'complex concepts' that KK was apparently unable to hold in mind were not spelled out by assessors. Baker J commented upon:

...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.<sup>250</sup>

This danger is supported by Williams, V., et al's (2012: 6, 123) research, which described the collapsing together of mental capacity and best interests as a 'concertina effect'. Emmett et al (2012: 5) also found that 'best interests' and 'risks' were prominent factors in capacity assessment.

Unusually, KK gave oral evidence to the court, in which she declared: 'If I die on the floor, I die on the floor. I'd rather die in my own bungalow, I really would',<sup>251</sup> suggesting she had a vivid appreciation of the risks attached to her decision. The court found that she did not lack insight so much as evaluate the risks and advantages of a return home differently to professionals. The courts are not, however, always so expansive in their acceptance of a person's tolerance of risk or unhappy outcomes. Anorexia is often given as an example of situations where normative valuations about how a person should weigh the options may creep into capacity assessment (Banner, 2012b; Freyenhagen and O'Shea, 2013; Holroyd, 2010). The case *Re E (Medical treatment: Anorexia) (Rev 1)*<sup>252</sup> was a good example of this. The court found that E lacked capacity to make decisions about treatment as her:

...obsessive fear of weight gain makes her incapable of weighing the advantages and disadvantages of eating in any meaningful way... For E, the compulsion to prevent calories entering her system has become the card that trumps all others. The need not to gain weight overpowers all other thoughts.<sup>253</sup>

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<sup>247</sup> [33]

<sup>248</sup> [57]

<sup>249</sup> [32]

<sup>250</sup> [65]

<sup>251</sup> [50]

<sup>252</sup> [2012] EWHC 1639 (COP)

<sup>253</sup> *Re E (Medical treatment: Anorexia) (Rev 1)*, [49]

And yet, an alternate way of constructing E's decisions was available to the court, but was not given any serious consideration. Anorexia is a very serious condition with a significant mortality rate (Attia, 2010). E had attempted treatment for her anorexia many times in the past,<sup>254</sup> her parents and her medical team supported her request not to undergo further force feeding treatment.<sup>255</sup> The proposed treatment was estimated to have a 20-30% chance of success,<sup>256</sup> and was likely to be extremely distressing to E. In view of those considerations, it seems reasonable to suggest that E was not so much choosing not to eat, as making a choice to 'die with dignity'<sup>257</sup> having considered the trauma and poor prognosis of the proposed treatment options. Such a choice must, surely, be within the range of reasonable decisions a person with such a poor prognosis might make. The case of E is a good example of how framing the decisions at the core of capacity assessments differently could give rise to different outcomes. The power to frame the decision lies within the control of the assessor – and is a key potential source of arbitrariness in their decision making.

There is growing empirical evidence that mental capacity assessments are used to secure outcomes that assessors perceive to reduce risks or be in a person's best interests. The courts and researchers have described this as illegitimately conflating incapacity with 'unwise decisions'. Yet picking these apart may not be as easy as some would hope. In several places in this chapter I have argued that the courts have adopted outcome based approaches to capacity in various respects. Yet in a way, this is unavoidable – function must be read off from outcomes at some point, and outcomes must therefore be categorised according to whether they indicate 'good' or 'bad' function.

However much it is dressed up in 'neutral', 'cognitive' and medicalised language, mental capacity assessment is inherently and unavoidably normative (Banner, 2012b; Charland, 2001; Freyenhagen and O'Shea, 2013; Holroyd, 2010). From a republican perspective this is not necessarily problematic in itself, but republicans and others would call for transparency over the kinds of normative principles being applied. Clear and transparent principles for mental capacity assessments are essential if a person is to be able to challenge them. In republican terms, the danger of pseudo-cognitive 'mental' capacity assessment is that evaluative commitments are 'smuggled in' without discussion. Freyenhagen and O'Shea (2013: 26) comment:

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<sup>254</sup> *Re E (Medical treatment: Anorexia) (Rev 1)*, [16]-[17]

<sup>255</sup> *Re E (Medical treatment: Anorexia) (Rev 1)*, [81]

<sup>256</sup> *Re E (Medical treatment: Anorexia) (Rev 1)*, [90]. Additionally there is no research base for this estimate; forced feeding treatment for people in E's condition is not recommended by NICE. (Thanks to Timon Hughes-Davis for that observation).

<sup>257</sup> [76]

The main danger of such opacity [in the evaluative commitments of the MCA] is arbitrariness and undue discretionary authority in mental capacity assessment, which places assessors in positions of dominance, threatening the assessed individual's freedom, even if assessors exercise their powers responsibly.

There is a real danger in eschewing the development of clear and principled tests of capacity, out of what Hedley J described as 'an instinctive impatience simply to bring about the desired result whatever, which, if it stood alone, would simply be an unwise decision.'<sup>258</sup> This 'instinctive impatience' to bring about the desired result is sometimes understandable when one examines the facts of the particular case, and when one has faith in the judgement of the person making the decision. But the wider structural effects are unacceptable. It has led to a range of unprincipled contradictions in the common law on mental incapacity: from the influence of third parties on decision making, to the degree to which a person must 'understand' the risks posed by undesirable persons for the purposes of sex or contact with them, and the degree to which a person must understand and agree with professional appraisals of the risks of care and treatment refusal. If, as I have suggested, there is no straightforward guidance that can be provided to disentangle incapacity from 'unwise decisions', it would be more acceptable from the perspective of legal certainty to be upfront about the range of risky or unsettling outcomes we are prepared to tolerate. It is, furthermore, difficult to see how intervening to prevent these outcomes could be justified exclusively for people with disabilities and not all persons at risk. This would place people with disabilities, professionals and courts alike on a more secure footing, although it would require us to abandon the myth that the MCA is value-neutral.

#### THE 'PROTECTION IMPERATIVE'

The expansion of a 'best interests' jurisdiction into care and welfare issues established new tools, which could be used for protective purposes, and which endowed social care practitioners with 'fresh solutions and new responsibilities' (Hewitt, 2000: 202). In his ruling in *CC v KK and STCC* Baker J made the following observation:

...there is a risk that all professionals involved with treating and helping that person – including, of course, a judge in the Court of Protection – may feel drawn towards an outcome that is more protective of the adult and thus, in certain circumstances, fail to carry out an assessment of capacity that is detached and objective.<sup>259</sup>

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<sup>258</sup> *CYC v PC and NC*, [21]

<sup>259</sup> At paragraph 25. This observation was also made by Baker J in *PH v A Local Authority, Z Ltd and R* [2011] EWHC 1704 (Fam) [16], which in turn drew from comments made by Ryder J in *Oldham MBC v GW and PW* [2007] EWHC136 (Fam) [2007] 2 FLR 597.



The vagueness in the way incapacity is defined, coupled with what Baker J and Ryder J call the 'protection imperative',<sup>260</sup> is in danger of creating a slide towards low and variable thresholds for incapacity and hence for interferences in best interests.

Although in part the 'protective imperative' stems from what Ryder J observes to be 'a human response to the need to protect' a vulnerable person<sup>261</sup> there are also social and legal reasons why social care practitioners may be drawn towards adopting a lower incapacity threshold. I have outlined above a growing tendency in case law, LGO reports and SCRs to criticise social care practitioners for harms which befall a person as a result of risky choices they were later deemed to lack the mental capacity to make.<sup>262</sup> Although we have not yet seen a case in social care where practitioners have been found negligent or to have breached a person's human rights by failing to 'identify' their incapacity to make some unwise decision and act accordingly, it was earlier argued that it does not seem impossible that such a case might occur. Meanwhile the media, whilst on the one hand being extremely critical of social care professionals for 'interfering' in people's lives (Beckford, 2011; Butterworth, 2010; Kenber, 2011a; b; Reid, 2011; Taylor, 2011), can also be also extremely critical of courts and professionals alike for failing to override a person's choices where some harm later befalls them (Burnett, 2011; Wimbledon Guardian, 2011; Monckton, 2012).

Gareth Owen, a psychiatrist, has suggested that the caring professions find the MCA difficult because it allows for tragedy. 'People can genuinely feel that something that is unfolding [that] is going to have an unhappy ending' and we need, he suggests, 'to develop a 'tragic wisdom' that is 'willing to allow that there are endings that are not necessarily happy' (Cooper, 2011). Owen makes reference to Aristotle's *Poetics*, which argues that tragedies are characterised by a reversal of fortunes arising from a person's *Hamartia*, their mistake. Tragedies are, according to Aristotle, characterised by both seriousness and dignity. Yet it seems the public itself might not be ready to entertain the tragic wisdom of the dignity of risk, of accepting *Hamartia*, just yet.

Operating within a climate of only limited tolerance of risk, social care practitioners may themselves experience uncertainty over when it is acceptable to allow a person to make a harmful choice. In such circumstances, a person would want to have a robust assessment to fall back on, to demonstrate that the person had the mental capacity to make the choice and was prepared to accept the risks. Yet, when the criteria for mental capacity are flexible and poorly defined, it is understandable –

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<sup>260</sup> *CC v KK and STCC*, [65]; *Oldham Metropolitan Borough Council v GW & Ors* [2007] EWHC 136 (Fam) [86] and [97]

<sup>261</sup> *Oldham Metropolitan Borough Council v GW & Ors*, [97]

<sup>262</sup> A fact in itself worthy of remark since there is, by definition, no evidence derived from a capacity assessment to base this upon. In cases such as *Rabone*, *Re E (Medical treatment: Anorexia)* (Rev 1) and countless SCRs and LGO reports it seems to be taken for granted by those reflecting on past events that a person must have lacked capacity, either because of their status as a 'mental' patient or because of the decisions they made.

albeit not desirable - that an assessor might feel safer employing a more conservative threshold. The main effects of arbitrary thresholds in distinguishing incapacity from unwise decisions will be felt by those being assessed. However, even care practitioners may experience anxiety and fear of arbitrary criticism around the assessment of mental capacity and the public's conflicted desires for freedom from interferences and harm at the same time.

#### 4.4 PRINCIPLES RELATING TO 'BEST INTERESTS'

Once it has been established that a person lacks capacity, any act done or decision made on their behalf must be in their best interests.<sup>263</sup> Section 4 MCA provides a lengthy 'checklist' of issues that best interests decision makers must consider and people whom they must consult where reasonable practicable. Best interests decisions will be compliant with s4 MCA if decision makers reasonably believe 'that what he does or decides is in the best interests of the person concerned'.<sup>264</sup> The considerations and consultation duties are as follows:

- Decision makers must not make assumptions about what is in a person's best interests 'merely' on the basis of their age, appearance condition or aspects of their behaviour.<sup>265</sup>
- They must consider whether it is likely that P will gain or regain the capacity to make the decision himself in the future.<sup>266</sup>
- They must 'so far as reasonably practicable, permit and encourage the person to participate, or to improve his ability to participate, as fully as possible in any act done for him and any decision affecting him.'<sup>267</sup>
- They must consider, so far as reasonably ascertainable, 'the person's past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity)', any beliefs or values 'that would be likely to influence his decision if he had capacity', and 'other factors that he would be likely to consider if he were able to do so'.<sup>268</sup>
- Decisions about life-sustaining treatment must not be 'motivated by a desire to bring about his death'.<sup>269</sup>
- So far as reasonably practicable, they must consult with anyone named by P 'as someone to be consulted on the matter in question or on matters of

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<sup>263</sup> s1(5) MCA

<sup>264</sup> s4(9) MCA

<sup>265</sup> s4(1) MCA

<sup>266</sup> s4(3) MCA

<sup>267</sup> s4(4) MCA

<sup>268</sup> s4(6) MCA

<sup>269</sup> s4(5) MCA

that kind', 'anyone engaged in caring for the person or interested in his welfare', and 'any donee of a lasting power of attorney granted by the person', and 'any deputy appointed for the person by the court'.<sup>270</sup>

Despite the quite elaborate procedural requirements of s4 MCA, the broad scope for interpretation and different 'weighing' of considerations means best interests is more akin to a 'standard', 'whose elements are insufficiently determined by language', than a legal rule (Solan, 2012: 466). The checklist does not prioritise any particular considerations or perspectives. The courts often draw up a 'balance sheet' to weigh up different considerations,<sup>271</sup> and the approach under s4 MCA is sometimes described as 'objective' in contrast with substituted judgments approaches whereby the Court tried to divine the decision which the patient would have made if competent.<sup>272</sup> Coggon (2008a: 219) argues that the flexibility of best interests under the MCA 'allows for differences in values, and is thus ...appropriate in a pluralist liberal system.' However, as discussed with the definition of mental capacity itself, flexibility can all too easily stray into arbitrariness without the guidance of clear and well known principles. Given the significance of the issues which may hinge upon the outcome of best interests decision, it is important from a republican perspective that parameters which may lead to different outcomes are suitably constrained. In this section I review how far 'best interests' case law has provided clear and consistent principles to guide the kinds of interferences which characterise 'institutional domination'.

#### 4.4.1 GENERAL BEST INTERESTS PRINCIPLES

Before considering specific areas of concern, a few recurring general issues in best interests case law will be reviewed. The first is the weight and importance that should be attached to P's wishes and feelings. HH Marshall J has held that wherever P's wishes are not 'irrational', 'impracticable' or 'irresponsible' this 'effectively gives rise to a presumption in favour of implementing those wishes'.<sup>273</sup> However, Lewison J held that this 'may have slightly overstated the importance to be given to P's wishes', observing 'The only imperative is that the decision must be made in P's best

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<sup>270</sup> s4(7) MCA

<sup>271</sup> Developed by Thorpe J in *Re A (Male Sterilisation)*. See *NHS Trust v K & Ors* [2012] EWHC 2922 (COP) for a good recent example of the use of this approach.

<sup>272</sup> This is discussed by Munby LJ, who observes that the two approaches were, 'in principle, capable of reaching different outcomes on the same set of facts' (Lord Justice Munby, 2011: 33). However, elements of substituted judgment do live on under the MCA although it is not determinative, see: *Re G (TJ)* [2010] EWHC 3005 (COP) (payment of maintenance to family members); *Re JC; D v JC* (2012) MHLO 35 (COP) - in which Judge Lush expressed the view that substituted judgment had advantages over the 'balance sheet' approach in statutory will cases.

<sup>273</sup> *Re S & S (Protected Persons)*[2008] CoPLR Con Vol 1074 [57]

interests'.<sup>274</sup> Munby LJ considered this issue at length in *ITW v Z & Ors*<sup>275</sup>, saying that P's wishes and feelings were always a 'significant factor' although there was no a priori weight attached to them, which would always be case-specific and fact-specific.<sup>276</sup> However, he observed that the following factors would be influential in determining how much weight to attach to P's wishes and feelings:

- 'the degree of P's incapacity, for the nearer to the borderline the more weight must in principle be attached to P's wishes and feelings',<sup>277</sup>
- 'the strength and consistency of the views being expressed by P';
- 'the possible impact on P of knowledge that her wishes and feelings are not being given effect to';<sup>278</sup>
- 'the extent to which P's wishes and feelings are, or are not, rational, sensible, responsible and pragmatically capable of sensible implementation in the particular circumstances';
- 'crucially the extent to which P's wishes and feelings, if given effect to, can properly be accommodated within the court's overall assessment of what is in her best interests'.<sup>279</sup>

Munby LJ's guidance is doubtless helpful in expanding the best interests balance sheet to cover important considerations, but these principles are not determinative guidance for any given case. A related consideration impacting upon best interests may be how far a person's expressed wishes and preferences are regarded as *authentically* theirs. For example, in *K v LBX* the influence of his father on his ability to articulate his own wishes meant that his wishes would hold less weight for determining his best interests.

A second theme that recurs through much 'welfare' case law is the balancing of 'happiness' and 'risk'. In *Local Authority X v MM and KM* Munby LJ warned that:

...we must avoid the temptation always to put the physical health and safety of the elderly and the vulnerable before everything else... Physical health and safety can sometimes be bought at too high a price in happiness and emotional welfare. The emphasis must be on sensible risk appraisal, not striving to avoid all risk, whatever the price, but instead seeking a proper balance and being willing to tolerate manageable or acceptable risks as the price appropriately to be paid in order to achieve some other good – in particular to achieve the vital

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<sup>274</sup> *Re P* [2009] EWHC 163 (Ch) [41]

<sup>275</sup> [2009] EWHC 2525 (Fam)

<sup>276</sup> [35]

<sup>277</sup> Citing *Local Authority X v MM and KM* [124]

<sup>278</sup> *Ibid*

<sup>279</sup> *Re M; ITW v Z & Ors*, [35]

good of the elderly or vulnerable person's happiness. What good is it making someone safer if it merely makes them miserable?<sup>280</sup>

This passage has been cited frequently in case law,<sup>281</sup> and in an extra-curial speech Munby LJ added to it this passage: 'And if this is where safeguarding takes us, then is it not, in truth, another form of abuse – and, moreover, abuse at the hands of the State?' (Lord Justice Munby, 2012b).<sup>282</sup> The difficulty is that describing excessive paternalism as potentially another form of abuse does not help to define the line across which 'physical health and safety has been bought at too high a price in happiness'. The statement is very helpful for decision makers and courts seeking to make less risk averse decisions that promote emotional welfare, but it does not offer especially clear guidance about the risks that can be tolerated.

#### 4.4.2 BEST INTERESTS AND THE PROBLEMS OF DOMINATION IN SOCIAL CARE

The problem of institutional domination can be broken down into two interconnected sets of issues:

1. The decision to place a person in an institution, and whether or not they can leave it, as an interference in itself.
2. The interferences with a person's choices and freedoms which they may be subjected to within an institution.

These issues are interconnected in a variety of ways. Firstly, as argued in Chapters 1 and 2, whether or not we recognise a place as an 'institution' will to some extent depend on the degree to which residents' everyday choices and freedoms are eroded by staff in that setting. Secondly, whether or not it is in a person's best interests to place them in an institution will depend upon perceptions of the conditions within that institution. Thirdly, the conditions within an institution will become more restrictive if a decision has been taken to prevent a person from leaving it. Fourthly, where a population cannot exercise choices over where they live, and whether they can leave, they are more 'dependent' and hence more at risk of domination according to republican philosophers.<sup>283</sup>

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<sup>280</sup> *Local Authority X v MM & Anor (No. 1)*, [120]

<sup>281</sup> For example: *Re A (Capacity: Refusal of Contraception)* [76]; *G v E & Ors* [2010] EWHC 621 (COP) [74]; *A Local Authority v DL & Ors* [2010] EWHC 2675 (Fam) [21]; *CC v KK & STCC* [2012] EWHC 2136 (COP) [66]

<sup>282</sup> This version is also cited in *CC v KK & STCC* [66]

<sup>283</sup> See section '2.3.1 Necessary but insufficient conditions of domination: Dependency and imbalance of power' in Chapter 2.

## 4.5 INVOLUNTARY PLACEMENT: MENTAL CAPACITY, PUBLIC LAW AND BEST INTERESTS

In Chapter 2 various concerns around involuntary placement were described. These included placements far from a person's family and home communities which were damaging to family relationships; people so placed were described as amongst the most socially excluded people in the UK. There were also concerns about people being placed in inappropriate accommodation of various kinds, including in group homes if they had 'challenging behaviour'. Empirical research also suggests that tensions can arise between families and professionals over involuntary placements, especially where professionals are influenced by 'normalisation' approaches which advocate adults with learning disabilities moving out of the family home into 'independent' accommodation.

Understanding the legal mechanics of 'involuntary placement' in England requires some understanding of the public law powers and duties of public authorities to provide care services, and how these intersect with the MCA. Unfortunately this is no mean task in a field which, as Jackson J recently put it, is 'not legally coherent and bristles with intricate regulation'<sup>284</sup>. This discussion will only give an overview in the broadest terms.<sup>285</sup> The entire field of community care law will shortly be re-codified by the Draft Care and Support Bill (2012), which clarifies many uncertainties in the law but leaves the essentials unchanged (see: Law Commission, 2008; 2011).

Although the detail is often highly complex, the basics of community care law are simple. A local authority must conduct an assessment of the community care needs of any person where it appears to them that they might be eligible for services which a local authority may provide.<sup>286</sup> Authorities are entitled to consider their resources when they decide what level of needs they are prepared to meet in their area. However, if a person's assessed needs meet this threshold then the authority

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<sup>284</sup> *London Borough of Hillingdon v Neary & Anor*, [19]. Other judges have described community care law as complex, labyrinthine and obscure (*Crofton v NHS Litigation Authority* [2007] EWCA Civ 71, [2007] 1 WLR 923 at [110]), poorly drafted and confusing (*R v Liverpool Health Authority* [2002] Lloyd's Rep Med 23 [5]) and as giving rise to a 'paper chase' (*R (AW) v Croydon LBC and Hackney LBC* [2007] EWCA Civ 266, [2007] 1 WLR 3168 [55]).

<sup>285</sup> A good overview of community care law is given by the Law Commission in their scoping report for a new consolidation statute for Adult Social Care (Law Commission, 2008), and Mandelstam (2010) has written an excellent short introduction. Clements and Thompson (2011) have produced the most comprehensive and up to date guide to community care law at the time of writing.

<sup>286</sup> s47 NHS and Community Care Act 1990. See also *R v Bristol City Council Ex p. Penfold* (1998) 1 CCLR 315 for confirmation that the duty to assess arises even in respect of needs which the local authority has no duty to meet, but has a discretionary power to do so if it so chose. The Draft Care and Support Bill (2012) explicitly provides that a local authority must carry out such an assessment even where a person refuses it, if they lack capacity and the authority are satisfied that an assessment is in their best interests.

must meet them through the provision of care services, regardless of the cost.<sup>287</sup> The government attempted to homogenise the process of defining 'eligible' needs by introducing binding guidance – euphemistically entitled 'Fair Access to Care Services' – which distinguished between 'low', 'moderate', 'substantial' and 'critical' levels of need across several domains (Department of Health, 2003a; updated in: Department of Health, 2010c). Authorities can decide whether to meet 'low', 'moderate', 'substantial' or 'critical' needs.<sup>288</sup> Assessors must identify which of a person's 'presenting needs' are eligible for community care services by reference to the threshold adopted by their local authority.

Although all eligible needs must be met, authorities have considerable discretion in how they might choose to meet them, and they must also have regard for the 'best value' way to discharge their powers and duties.<sup>289</sup> Authorities are obliged to 'take all reasonable steps to reach agreement with the person and, where they think it appropriate, any carers of that person, on the community care services which they are considering providing to him to meet his needs' (Department of Health, 2004: [2.3]). However, if an authority makes a 'reasonable offer' of a service which would meet a person's eligible needs then they are not obliged to offer a person a different service which would have greater resource implications.<sup>290</sup> As 'public functions' under s6 HRA, assessment and the provision of support must be compatible with a person's ECHR rights. The authority might offer support to enable a person to continue living in the family home if that is where they currently are,<sup>291</sup> or it might make an offer of a placement in a supported living service<sup>292</sup> or a residential care home.<sup>293</sup> In a small proportion of cases, a person's needs might qualify as 'health' not 'social care' and so be commissioned through the NHS as 'continuing care'.<sup>294</sup>

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<sup>287</sup> Following the 'Gloucestershire judgment' in *R v Gloucestershire County Council & Anor ex p Barry* [1997] UKHL 58. See also *R (KM) v Cambridgeshire County Council* [2012] UKSC 23 for a recent affirmation of the ruling in Barry.

<sup>288</sup> According to ADASS (2012) 1.4% councils set theirs at low, 13.4% at Moderate, 83.1% at Substantial and 2.1% at Critical. Local authorities are raising their eligibility thresholds in response to budgetary pressures; in 2010/11 only 70% of local authorities meet only substantial needs or greater (Association of Directors of Adult Social Services, 2011).

<sup>289</sup> s3 Local Government Act 1999

<sup>290</sup> *Khana v London Borough Of Southwark*. However, the court did hold that if two courses were available which could meet a person's eligible needs and there were no resource implications, then if a person refused a service which they did not prefer the local authority may not have discharged its statutory duties [59].

<sup>291</sup> Community based services are usually provided under the Chronically Sick and Disabled Persons Act 1970, but this could also be under s117 MHA or other statutes.

<sup>292</sup> Technically, this would also constitute a 'community based service', and usually be provided under Chronically Sick and Disabled Persons Act 1970, as it would be support to a person in their own home.

<sup>293</sup> Usually under s21 and s29 National Assistance Act 1948, but this could also be under s117 MHA or other statutes.

<sup>294</sup> The boundaries between health and social care, and therefore local authority and NHS funding, are extremely complex, see Clements and Thompson (2011: Chapter 20) for discussion. Continuing care funding is not determined by the type of setting a person lives in (*R*

Where a person is already receiving care services the authority must conduct reviews of their care needs.<sup>295</sup> At these reviews the authority may decide to make available an alternative offer of a different way of meeting a person's eligible needs. In some cases, this may mean that a person may have to move from one setting to another because assessors have changed their view of their needs, or of how they might be met.<sup>296</sup> But the local authority is under no automatic obligation to make available offers of alternative support arrangements simply because a person does not like the service they are receiving. In this way, public law may shape the availability of 'alternatives' which in turn influence whether or not a person is 'free to leave' a particular setting. This is highly relevant to the question of whether or not they are deprived of their liberty, discussed in Chapter 6.

The intersection between community care law and the MCA is complex, sometimes contentious and is still evolving. Local authorities making 'best interests' decisions on behalf of people they deem to lack the capacity to make decisions about their care arrangements appear to be relying upon ss5-6 MCA; it is very rare that formal authority in the form of a court order or welfare deputyships is sought.<sup>297</sup> The combination of the MCA and local authorities public law powers and duties to provide community care services, appears to have created a remarkably potent, yet informal, mechanism for involuntary placement in community care institutions.<sup>298</sup>

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*v North and East Devon H.A. ex parte Coughlan* (2000) 2 WLR 622), however those living in long-stay healthcare settings are almost certainly funded through continuing care arrangements rather than by the local authority. The Department of Health (2009b) has produced guidance on the boundary between 'continuing healthcare' and 'social care' eligibility.

<sup>295</sup> There is no statutory requirement to conduct reviews of community care needs, but binding guidance states 'The frequency of reviews should be proportionate to the circumstances of the individual but there should be an initial review within three months of help first being provided or major changes made to current support plans. Thereafter, reviews should be scheduled at least annually or more often as is necessary.' The guidance goes on to say that 'Adults lacking capacity are likely to need more frequent monitoring arrangements than other service users. They may be less able to communicate their needs and wishes and there may be issues around fluctuating capacity.' (Department of Health, 2010c: [144], [146]). There is a duty to conduct reviews in the Draft Care and Support Bill (clause 26).

<sup>296</sup> See, for example, *AH v Hertfordshire Partnership NHS Foundation Trust* [2011] EWHC 276 (COP), where the local authority sought to move 12 adults from residential care to alternative homes. This was found not to be in their best interests because of the 'turmoil of a move' [78], which could only be justified by the service closing.

<sup>297</sup> This must be the case as whilst it is estimated that as many as two-thirds of people using community care services lack the capacity to consent to their use (Department of Health, 2005a), the Court of Protection makes only a few hundred welfare orders and deputyships each year (see Appendix C for data).

<sup>298</sup> This informal mechanism will be given statutory recognition by the Draft Care and Support Bill (2012), which places local authorities under a duty to meet eligible needs where 'the adult lacks capacity to arrange for the provision of care and support' and no person is authorised to do so under the MCA (clause 17).



#### 4.5.1 BEST INTERESTS, AND THE TENSION BETWEEN FAMILY LIFE AND 'NORMALISATION'

A recurrent theme in Court of Protection case law is whether it is in the 'best interests' of people with learning disabilities to live with their families or in some form of institutional accommodation. Sometimes this takes the form of whether or not a person should leave the family home,<sup>299</sup> in other cases it concerns whether or not they should move back to live with them.<sup>300</sup> As most of these types of cases occurred after the HRA came into force, these questions are typically considered by the courts through the lens of Article 8 ECHR, the right to respect for home, family and private life.

Sedley LJ established in *Re F (adult patient)* that Article 8 did not prohibit the state from intervening in family life where there were serious concerns that 'other individuals, however closely related and well-intentioned' could 'create or perpetuate situations which jeopardise their welfare.'<sup>301</sup> In *Re S (Adult Patient) (Inherent Jurisdiction: Family Life)*, Munby LJ found that different elements of Article 8 could come into conflict. A parents' right to family life might be engaged by their desire for their adult son or daughter to remain at home with them, but the desire of competent sons or daughters' to leave home and exclude their parents from their 'inner circle' was protected by their Article 8 right to private life.<sup>302</sup> In respect of adults who lacked capacity, however, Munby LJ made the following statement:

I am not saying that there is in law any presumption that mentally incapacitated adults are better off with their families: often they will be; sometimes they will not be. But respect for our human condition, regard for the realities of our society and the common sense to which Lord Oliver of Aylmerton referred in *In Re KD*, surely indicate that the starting point should be the normal assumption that mentally incapacitated adults will be better off if they live with a family rather than in an institution - however benign and enlightened the institution may be, and however well integrated into the community - and that mentally incapacitated adults who have been looked after within their family will be better off if they continue to be looked after within the family rather than by the State.<sup>303</sup>

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<sup>299</sup> *Re S (Adult Patient) (Inherent Jurisdiction: Family Life)*; *K v LBX*.

<sup>300</sup> The following cases concern people with learning disabilities who were accommodated as children in institutional settings and continued to do so once they became adults or fell under the jurisdiction of the MCA (over the age of 16): *Re F (adult patient)* [2000] EWCA Civ 192; *RT v LT & Anor* [2010] EWHC 1910 (Fam); *P & Q v Surrey County Council* [2011] EWCA Civ 190; *RK v BCC* [2011] EWCA Civ 1305. Other cases concern adults who are in local authority accommodation, where their families or foster carers want them to return to live with them: *A Primary Care Trust v P*; *Re MP, LBH v GP* [2009] EWHC (Fam) (Case no FD08P01058, unreported, 8 April 2009); *G v E, A Local Authority & F* [2010] EWHC 621 (Fam); *London Borough of Hillingdon v Neary & Anor*.

<sup>301</sup> No paragraph numbers, but see penultimate paragraph.

<sup>302</sup> [37]

<sup>303</sup> [48]

This passage has been quoted in a large number of cases on best interests,<sup>304</sup> often as an authority for a general preference for placements in the family home over ‘institutional’ care. Statements endorsing family over institutional placements can be found elsewhere in Court of Protection case law. In *P & Q v Surrey County Council*, Wilson LJ stated that if a person was ‘is living with her parents or other members of his natural family in their home, she is living – in that respect – the most normal life possible’.<sup>305</sup> Hewitt (2012) finds ‘something special – something almost mystical’ about family life in these remarks. Yet there are uncomfortable infantilising overtones to the assumption that it is ‘natural’ for adults with learning disabilities to remain living in the parental home, an assumption which would be unlikely to hold for non-disabled adults. The right of adult children to personal development outside the family home espoused by Munby LJ was discussed only in connection with *competent* adults.<sup>306</sup>

A contrasting view of what living arrangements are more desirable for adults with learning disabilities comes from the principles of normalisation, that disabled people should be free to live their lives ‘on the same terms as others in society’ (Perrin and Nirje, 1985; cited in Deeley, 2002: 21), outlined in Chapter 2. Early decisions which found that it was not in a person’s best interests to remain living their families involved exposure to abuse<sup>307</sup> or neglect,<sup>308</sup> but in recent years the courts have also begun to regard the opportunity to experience ‘independent living’ as in itself a factor in determining best interests. In *A Primary Care Trust v P*, discussed above, there were serious concerns about P’s mother not adhering to the medication regime for his epilepsy. However it was also held that if he remained with his mother he would never experience ‘the making of a true choice about independence’<sup>309</sup> and a move would ‘free him from the dominating effects of an obsessive and smothering relationship’.<sup>310</sup> In *K v LBX*, also discussed above, L’s father invoked Munby LJ’s ‘starting point’ assumption that ‘mentally incapacitated adults will be better off if they live with a family rather than in an institution’. In favouring a move to supported living arrangements the judge at

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<sup>304</sup> Including at a minimum the following cases: *London Borough of Newham v BS & Anor* [2003] EWHC 1909 (Fam) [19]; *Local Authority X v MM & Anor* (No. 1) [115]-[117]; *A Local Authority v E* [2007] EWHC 2396 (Fam) [66]; *LLBC v TG* [2007] EWHC 2640 (Fam) [30]; *London Borough of Ealing v KS & Ors* [2008] EWHC 636 (Fam) [108]; *A Local Authority v A (A Child) & Anor* [72]; *A London Local Authority v JH & Anor* [2011] EWHC 2420 (COP); *A London Borough v BB & Ors* [2011] EWHC 2853 (Fam) [47]; *London Borough of Hillingdon v Neary & Anor* [154].

<sup>305</sup> [28]

<sup>306</sup> [37]

<sup>307</sup> *BB v AM* [2010] EWHC 1916 (Fam)

<sup>308</sup> *Re MP, LBH v GP*

<sup>309</sup> [63]

<sup>310</sup> [64]

first instance<sup>311</sup> had relied upon the following passage from an unreported case by Roderic Wood J:

It does seem to me, with the greatest of respect to Munby J, that I should record that in my more recent experience of such cases it is very much the approach when dealing with incapacitated adults that whilst in many cases the family may be the providers of care and nurture for such adults, there seems to me to be a philosophical and practical shift towards ensuring as greater degree of independence in living arrangements as is possible.

The OS argued on behalf of L that ‘adults should be assisted to have the greatest control over their lives consistent with their disability, and to have the same opportunities as anyone else’, including opportunities to live independently ‘according to the adult’s wishes.’<sup>312</sup> Perhaps surprisingly, given the use to which Munby LJ’s passage has been put, the Court of Appeal was ‘far from convinced that Munby J’s decision in *Re S* did in fact establish a formal starting point’ regarding how a judge should approach the question of best interests, rather than ‘what would be many people’s natural reactions’.<sup>313</sup> Black LJ reiterated Munby LJ’s observation that Article 8 ECHR contained an ‘inherent conflict’ between the ‘right to personal development’ and relationships with the outside world in private life and the right to family life.<sup>314</sup> The Court of Appeal’s judgment did not establish ‘independent living’ as a new starting point, but concluded that a person’s welfare was the paramount consideration and that ‘A balanced consideration of all the circumstances and attention to what is required by Article 8 is all that is required.’<sup>315</sup> It was found to be in L’s best interests to experience ‘independent living’.

It appears from these judgments that over the last decade there has been a slow shift in the ideological influences on best interests decisions concerning family life and ‘independent living’. This is a good example of the ‘labile existence’ of law described by Golder and Fitzpatrick (2009: 77, 82), and the responsiveness of welfare jurisdictions to ‘changes in social attitudes’.<sup>316</sup> Yet whilst it might be thought desirable that ‘normalisation’ philosophies have come to influence best interests case law, the use of ‘independent living’ in these cases is somewhat paradoxical. Independent living is a central plank of the modern disability rights movement, yet its meaning in these cases appears to have become conflated with those services which are called

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<sup>311</sup> The first instance judgment by Theis J in this case has not been published. Her judgment, and Roderic Wood’s unreported judgment, are cited in the Court of Appeal judgment at paragraph 27.

<sup>312</sup> [28]

<sup>313</sup> [47]

<sup>314</sup> [56]

<sup>315</sup> [56]

<sup>316</sup> *Re G (Children)* [33], see also *J v C*

‘supported living’ (e.g., Law Commission, 2011: [4.9]). As noted in Chapter 2, supported living services can take on highly institutional characteristics. By contrast, independent living as conceived by disability rights campaigners emphasises the importance of a person being able to exercise choice and control over his or her everyday activities and the form of support they receive (Independent Living Institute, 2013; Mladenov, 2012; Morris, J., 1994; Morris, J., 2004). Article 19 CRPD, the right to independent living, specifies that disabled people should enjoy ‘the opportunity to choose their place of residence and where and with whom they live on an equal basis with others and are not obliged to live in a particular living arrangement’. This element of choice of living arrangement would appear to be contradicted in cases like *A Primary Care Trust v P* where a move to ‘independent living’ is imposed upon a person.<sup>317</sup> Despite growing domestic commentary on the ‘social and economic’ side of Article 19, surprisingly little has been devoted to the ‘civil and political’ elements of independent living which are linked to legal capacity (e.g. Joint Committee on Human Rights, 2012; Office for Disability Issues, 2011). However, the link between legal capacity and independent living has been drawn at an international level (Centre for Disability Law & Policy, 2011; Lewis, 2011; Parker, 2011).

As Nussbaum (2009: 332) notes, often in the context of cognitive disability, civil and political rights can be more controversial than social and economic rights. As these cases suggest, the relationship between legal capacity, choice and independent living can be complex and contested, especially where a person’s choices may be heavily influenced by third parties. From some perspectives, these cases might be regarded as evidence of what Quinn (2009: 217) calls a ‘textual toehold’ in the CRPD which can be used to dilute more radical interpretations of the treaty. Yet if disability campaigners are uneasy with the use of ‘independent living’ and ‘supporting capacity’ to justify interventions which override a person’s wishes and preferences, they will need to provide much more detailed and practical guidance and commentaries for situations like *A Primary Care Trust v P* and *K v LBX*.

From a republican perspective, the shift from the ‘starting point’ of a preference for care in the family home to these later ‘normalisation’ influenced decisions are notable for the temporary instability they created around the interpretation of Article 8 in these cases. Such instabilities are inevitable if ‘welfare’ jurisdictions and human rights law are to be ‘living instruments’ which respond to social change. However, they do create a greater risk of arbitrariness through opening up unanticipated shifts in

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<sup>317</sup> The degree to which L wishes to move out of the family home in *K v LBX* is somewhat ambiguous in the judgment. Despite the Official Solicitor referencing ‘the opportunity to live independently as an adult rather than with one’s family and the opportunity to live with one’s family with appropriate support, according to the adult’s wishes’ [28], K’s wishes are not clearly described in the judgment; if anything he appears happy living at home, but there is doubt as to whether this reflects his ‘true’ wishes.

permissible interferences. It is important that such shifts of interpretation are widely and clearly communicated to those exercising power and those affected by it if this temporary arbitrariness is to be as limited in duration as possible. It is, therefore, deeply troubling that the earlier rulings that influenced the Court of Appeal in *K v LBX* were not published.

Republicans might, however, take a more sympathetic view of state intervention in these cases. In *A Primary Care Trust v P* the local authority expressed concerns about ‘the dominating effects of an obsessive and smothering relationship’<sup>318</sup>, and in *K v LBX* about ‘concern had been expressed that L was in an environment in which he could not articulate his own wishes, as opposed to what he perceived to be the wishes of his father’.<sup>319</sup> Both cases suggest that local authorities were acting to remove people from settings where they might be ‘dominated’ by family carers, a concern which would be looked upon approvingly by republican theorists. However, we must be careful about too readily assuming that state action to remove a person from one place of domination enhances liberty; it is equally possible that such persons are subjected to a form of ‘decentralised’ domination (Lovett, 2010a: 52-3) where they are subject to arbitrary interferences wherever they live. We should be especially cautious of this, since these ‘normalisation’ inspired interpretations of Article 8 and best interests appear to set a much lower threshold for intervention than older cases where there was a background of physical abuse or neglect.

#### 4.5.2 BEST INTERESTS AND RESOURCES

One developing area of the complex interface between the MCA and public law is the extent to which additional resources must be made available for decisions in a person’s best interests. The received wisdom is that the MCA, and by corollary the Court of Protection, cannot require a public authority to provide treatment or services which it is not already required to do under public law.<sup>320</sup> This issue has a parallel in child welfare proceedings, where Lady Hale held in *Holmes-Moorhouse v Richmond-upon-Thames London Borough Council*<sup>321</sup> that ‘Family courts have no power to conjure up resources where none exist.’<sup>322</sup> This means that although the MCA requires best interests decisions to be made with additional consideration of the least restrictive option, in practice best interests decision makers may have to select from an unattractive set of options, all of which might be quite restrictive of a person’s rights

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<sup>318</sup> *A Primary Care Trust v P*, [64]

<sup>319</sup> [7]

<sup>320</sup> *A Local Authority v PB* [2011] EWHC 502 (COP); *R (Chatting) v Viridian Housing* [2012] EWHC 3595 (Admin) [99]-[100]; see also *Re AVS*; *CS v A NHS Foundation Trust* [2010] EWHC 2746 (COP) for application of this principle to medical decisions.

<sup>321</sup> [2009] 1 WLF 413

<sup>322</sup> [38]

and freedoms. One consequence of ‘focusing only on the options available on the day’, as Bartlett (2012a: 842) has observed, ‘is that it creates no impetus for change’. A cynic might observe that the MCA creates a remarkably friction-free mechanism to insert people into care services which those with capacity might, reasonably enough, object to – so long as those services remain the best of the available alternatives. Where support for a person to remain living with family or in their own home carries significant cost implications, limited resources may increase the probability that the MCA will be used to place them in an institutional setting.

However, the interface between the MCA and public law may not be quite so simple as these readings would suggest. Decisions made under the MCA will often represent a significant interference with a person’s human rights, particularly their Article 8 rights to respect for home, family and private life. Efforts to leverage additional community care resources out of local authorities using positive obligations under Article 8 have tended to meet with only limited success. In *R (Bernard) v London Borough of Enfield*<sup>323</sup> a local authority was found to have failed to discharge its positive obligations to restore a woman’s dignity under Article 8 when it failed to act upon a community care assessment which identified eligible needs. However, the circumstances of Bernard were quite extreme; the local authority had failed to provide any assistance to help Mrs Bernard access the bathroom, with the result that she was frequently forced to soil her clothes and floors of their home. In more recent cases – most notably *R (McDonald) v Royal Borough of Kensington and Chelsea*<sup>324</sup> - the courts have been less inclined to find that positive obligations to make available additional community care resources arise out of Article 8.

Often the interferences permissible under the MCA can raise unusual human rights questions which would not arise in respect of adults who are said to have mental capacity. For example, several cases have concerned people who are said to lack the capacity to consent to sexual relations – and so local authorities have put in place care arrangements which involve a high degree of monitoring and control in order to prevent a person from having sex.<sup>325</sup> Such arrangements are likely to incur greater costs than care plans which did not involve such a high degree of surveillance and control. The use of restraint can also engage human rights considerations, and sometimes alternatives to particular forms of restraint in order to avoid a breach of a person’s human rights may have cost implications.<sup>326</sup>

In *Local Authority X v MM & KM* Munby J held that MM lacked the capacity to make decisions about contact with her boyfriend, but not to consent to sex with him.

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<sup>323</sup> [2002] EWHC 2282 (Admin)

<sup>324</sup> [2011] UKSC 33

<sup>325</sup> *D Borough Council v AB; A Local Authority v H.*

<sup>326</sup> See, for example, *C v A Local Authority* – discussed in more detail below.

Consequently, Munby J held that if the local authority were going to restrict his access to her in her home, they must make available an alternative space – he suggested a hotel room - where she could enjoy private time with him. The local authority retorted that they were under no public law obligation to provide service users with facilities to enable them to enjoy sexual relations.<sup>327</sup> Munby J endorsed the following argument, relying upon *R (Limbuela) v Secretary of State for the Home Department*<sup>328</sup>:

...if the local authority seeks to interfere in – indeed, control – her life by saying where she must live, by placing her on her own somewhere where KM is not even allowed to visit her, and by controlling KM's access to her, then, says Mr Sachdeva, the situation is very different. The local authority is by its own acts creating a situation where, if a breach of Article 8 is to be avoided, the local authority must take certain positive steps – specifically, steps to enable MM to continue, in an appropriate and dignified way, her sexual relationship with KM.<sup>329</sup>

It would appear that positive obligations to make available additional resources may arise where the acts of a public authority give rise to an interference with a person's rights. Such acts may be more likely to occur where public authorities are empowered to intervene in a person's best interests.

Disputes around resources linked to the MCA can sometimes arise over whether or not public authorities are obliged to support a person to remain living in their own home or with family, even if this attracts additional costs. Article 19 CRPD contains a socio-economic element whereby states are expected to make support available for people with disabilities to live in the accommodation of their choosing on an equal basis with others. However, as with all socio-economic elements of the CRPD, states are only obliged to undertake this 'to the maximum of its available resources'.<sup>330</sup> Similar qualified rights may arise under Article 8 ECHR. For example in the case *R (Gunter) v South Western Staffordshire Primary Care Trust*<sup>331</sup> Article 8 was held to carry 'considerable' weight to provide support for a person to remain living with their family.<sup>332</sup> However, interests protected by Article 8 will always be qualified with respect to public resources, as the 'economic well-being of the country' constitutes one of the legitimate aims for interferences.

In recent years several NGOs have attempted to build upon the ECtHR's tentative concession in *Botta v Italy*<sup>333</sup> towards positive obligations under Article 8 to provide support for people with disabilities, towards an obligation to provide community-based, non-institutional living arrangements for people with disabilities

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<sup>327</sup> [161]

<sup>328</sup> [2005] UKHL 66; [2006] 1 AC 396

<sup>329</sup> [162]

<sup>330</sup> Article 4(2) CRPD

<sup>331</sup> [2005] EWHC 1894 (Admin)

<sup>332</sup> [21]

<sup>333</sup> (App No 21439/93) [1998] ECHR 12

(Cojocariu and Duffy, 2010; Mental Disability Advocacy Center, 2009). Whilst the ECtHR has conceded that a person should not ‘automatically’ be detained as a result of community based alternatives<sup>334</sup>, they have so far declined to examine the Article 8 issues raised in these cases and hence the associated matter of positive obligations.<sup>335</sup> Consequently, the degree to which human rights may be used to ward off institutional admissions in a person’s ‘best interests’ is still an uncertain and evolving area of domestic and Convention law.

## 4.6 INSTITUTIONAL DOMINATION IN THE COURTS

The first aspect of the problem of institutional domination is a person’s trajectory into a service and inability to leave it. Where a person has been placed in a setting through a concatenation of public authorities’ community care powers and the MCA a person becomes highly dependent upon their relationship with that care provider. As noted in Chapter 2, increased dependence on a relationship is a risk factor for a state of domination, but much will depend on the extent to which they are exposed to potential arbitrary interferences with their choices and freedoms. Insofar as they exist in a relationship which they are unable to leave, which exposes them to such potentially arbitrary interferences, a person is dominated. Having considered how a person might come to be placed in an institutional setting, I will now consider how far the courts have articulated clear criteria for when the interferences of concern in institutional settings are permissible. I focus primarily on how far MCA case law has constrained such interferences, but because of the MCA’s complex relationships with other areas of law, not least human rights law, I have also looked at some important cases which are not explicitly about ‘capacity’.

### 4.6.1 INSTITUTIONAL RULES AND REGIMES

Central to Goffman’s (1961: 43) much lauded analysis of ‘total institutions’ and their mortifying effects was the imposition of institutional rules and regimes, whereby ‘minute segments of a person’s line of activity may be subjected to regulations and judgements by staff; the inmates life is penetrated by constant sanctioning interaction from above’. Empirical studies and reports reviewed in Chapter 2 described a range of examples of this phenomenon, including institutions dictating when residents must wake up, wash, go to bed, restrictions on food choices – or an absence of food choices, restrictions on smoking, on going out, who they may talk to, when they may (or must) be in their own bedroom, etc.

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<sup>334</sup> *Stanev v Bulgaria*, [153]

<sup>335</sup> *Stanev v Bulgaria*, [252]; *Kędzior v Poland*, [93]-[94]



As discussed above, the primary mechanism which gives the MCA legal traction in community care settings is the general defence. For a defence to become relevant, it might be thought that there must be some kind of 'offence' for it to be invoked against. In several places the MCA code of practice suggests that the Act applies as much to everyday decisions like what a person wears or eats for breakfast, as 'major' decisions around care and treatment (Lord Chancellor's Office, 2007).<sup>336</sup> However, it is not entirely clear what kind of offence a person would be committing if they ignored the apparent requirement to apply the Act to everyday decisions. The MCA does not contain any independent right to autonomy, whatever its admirers claim; to identify why interferences which do not accord with the MCA are unlawful, we must look elsewhere.

The early case law which established the 'structural pillars' of the MCA were concerned with potential violations of tort law. In *Re F (Mental Patient: Sterilisation)* Lord Goff found that the doctrine of necessity protects 'the relative or friend or neighbour who comes in to look after [a man who has had a stroke], will commit no wrong when he or she touches his body.'<sup>337</sup> Yet the torts of trespass do not quite grasp the nature of the problem regarding institutional rules and regimes, concerned as they are with violations of bodily integrity or interference with a person's possessions. They address only situations where physical interferences occur,<sup>338</sup> not the effect of systems of rules and sanctions which a person might obey out of fear of being reprimanded or simply out of institutionalised deference to authority. The torts of trespass, with their tendency to focus on the particular act, seem ill equipped to tackle the cumulative, long-term and pervasive impact of living under authoritarian institutional regimes.

The ECHR rights offer a more promising avenue to render the imposition of institutional rules and regimes into serious justiciable issues. The domestic courts and ECtHR have considered some extreme rules and regimes in some prisons<sup>339</sup> and hospitals<sup>340</sup> through the lens of Article 3 ECHR, considering whether or not they were 'inhuman or degrading'. However the unfortunate ruling in *Herczegfalvy v Austria*<sup>341</sup>, which found that 'a measure which is a therapeutic necessity cannot be regarded as

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<sup>336</sup> See paragraphs [1.1], [1.8], [1.8], [3.3], [5.58], [6.1], [4.38], [4.60], [5.27] and [5.60].

<sup>337</sup> Page 25.

<sup>338</sup> Or are threatened to occur.

<sup>339</sup> *Napier v Scottish Ministers* [2004] ScotCS 100; 2005 1 SC 229, although being a Scottish case this would not have binding authority on English courts. See also *Callison v. Scottish Ministers* [2004] ScotCS 155 and *Grant & Anor v The Ministry of Justice* [2011] EWHC 3379 (QB) for cases where no violation of Article 3 was found in connection with prison regimes. The case *Price v United Kingdom* (App no 33394/96) [2001] ECHR 458 also finds a violation of Article 3 in relation to the degrading impact a prison regime had on a disabled prisoner when not suitably adapted for her needs.

<sup>340</sup> e.g. *Henaf v France* (App No 65436/01) [2005] 40 E.H.R.R. 44

<sup>341</sup> (App no 10533/83) [1992] ECHR 83, (1993) 15 E.H.R.R. 437

inhuman or degrading<sup>342</sup>, makes it very difficult to tackle measures which purport to have a therapeutic purpose. Bartlett (2013 [forthcoming]) writes that the ruling has ‘created considerable difficulties’<sup>343</sup> in bringing litigation about care and treatment within institutions for people with mental disabilities under Articles 3 and 8. In the recent case *Stanev v Bulgaria*, the ECtHR found for the first time that conditions in a social care facility violated Article 3, pointing to the inadequate heating, poor sanitation - with toilets ‘in an execrable state’, insufficient food and the duration for which residents were exposed to these conditions. The ECtHR also commented that the failure of the home to return the same clothes to same people after laundering ‘was likely to arouse a feeling of inferiority in the residents’.<sup>344</sup> This suggests that Article 3 can be used to tackle acts that individually might not amount to especially serious torts or crimes, but whose cumulative and long-term impact can amount to a violation of a most fundamental human right. However, because of the ruling in *Herczegfalvy* it may be more difficult to use Article 3 to unpick rules and regimes which take on a purported therapeutic aim.

Article 8 ECHR potentially has greater utility for tackling the kinds of rules and restrictions of concern in social care today because threshold of severity for engaging Article 8 is substantially lower than Article 3.<sup>345</sup> Being a qualified and not an absolute right the courts may be more willing to find violations, as a measure can thereby be restricted subject to justification, but not prohibited altogether. However, remarkably few cases have tested whether rules and restrictions in care services violate Article 8 ECHR and those which have are rather disappointing.

In *R (N) v Secretary of State for Health*<sup>346</sup> detained patients brought proceedings under s7 HRA against Nottinghamshire Health Care NHS Trust and the Secretary of State for Health, challenging a ban on smoking at Rampton Hospital. They argued that Article 8 protected individuals against interferences by the state in the privacy of their home, and that ‘their life, detained in a hospital like Rampton, can be equated to life at home’.<sup>347</sup> Lord Clarke and Moses LJ found that the smoking ban did not ‘have a sufficiently adverse effect on a patient’s physical or moral integrity’<sup>348</sup> to engage Article 8. They further held that a secure hospital ‘is not the same as a private home and the distinction is of significance’.<sup>349</sup> They said that ‘The degree to which a person may expect freedom to do as he pleases and engage in personal and private

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<sup>342</sup> [82]

<sup>343</sup> Page numbers unavailable as taken from a pre-publication draft.

<sup>344</sup> [209]-[210]

<sup>345</sup> See, e.g., *R (Bernard) v London Borough of Enfield*

<sup>346</sup> [2009] EWCA Civ 795; [2009] HRLR 31

<sup>347</sup> [31]

<sup>348</sup> [51]

<sup>349</sup> [40]

activity will vary according to the nature of the accommodation in which he lives.<sup>350</sup> Observing that Article 8 protected not merely a person's physical home but their 'inner circle' of social relations and activities,<sup>351</sup> the Court of Appeal went on to say that:

Any intrusion within that inner circle is offensive. It is the fact of intrusion into the home which offends, irrespective of the importance of the activity which an individual seeks to pursue within the home. But that inner circle, whilst not destroyed, is significantly penetrated by reason of the very fact that a person is confined within a secure hospital. The patient does not lose all right to a private life but the nature of that life and the activities which he may pursue are seriously restricted and always overlooked. No patient can choose freely what he eats or drinks. That is not simply because restrictions can be justified, but more fundamentally because of the nature of the institution in which he eats and drinks. Even if, pace Baroness Hale, a person may do as he pleases in his own home, no-one can expect such freedom when detained in a secure hospital.<sup>352</sup>

The ruling in *R (N) v Secretary of State for Health* is a troubling one. Their Lordships suggest that the protection offered by Article 8 may be diluted if a person lives in institutional accommodation. Inevitably shared accommodation brings in train compromises which may interfere with a person's rights to private life, but insofar as Article 8 is engaged they must still be proportionate, in pursuit of a legitimate aim and necessary in a democratic society. Yet the majority's analysis did not require such justification: Article 8 was not even engaged by the ban and they held that a person must expect such interferences 'not simply because restrictions can be justified' but because of their status as detained patients. In this passage the Lord Clarke and Moses LJ displayed significant reluctance to scrutinise the kinds of measures that might be imposed in institutional life. Keene LJ's dissenting judgment took a very different approach, and one which would be far more helpful for unpicking the kinds of concerns which animate this thesis. For him, smoking was a 'greatly valued' pastime for many people and so deserved the protection of Article 8,<sup>353</sup> including in an 'institution where he or she resides for a substantial amount of time'.<sup>354</sup> Observing that other mental hospitals had not found it necessary to impose such a ban, and that this specific ban had no parliamentary endorsement, Keene LJ found that it violated Article 8.<sup>355</sup>

In the Scottish case *Lyons v Board of the State Hospital*<sup>356</sup> a detained patient in the State Hospital sought judicial review of the hospital's introduction of a policy which

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<sup>350</sup> [41]

<sup>351</sup> Citing *Niemietz v Germany* (App no 13710/88) [1992] ECHR 80; 16 EHRR 97 [29]-[30]

<sup>352</sup> [44]

<sup>353</sup> [100]

<sup>354</sup> [101]

<sup>355</sup> [107]-[108]

<sup>356</sup> [2011] ScotCS CSOH\_21

prohibited visitors from bringing food for patients, restricted patients from ordering food from outside services except one takeaway meal per month, and introduced a pricing policy in the hospital shop to encourage healthy food purchases. Lady Dorrian found that the policy had been introduced unlawfully on procedural grounds, and so did make not any findings regarding the Article 8 issues raised by Lyons. However, she did discuss the Article 8 and was critical of the ruling of Lord Clarke and Moses LJ in *R (N) v Secretary of State of Health*, saying that it came:

...close to saying that the rights of a prisoner or the inmate of a high security hospital are limited merely and automatically as a result of their confinement, whereas the position ought to be that the prisoners retain their rights under article 8, interference with which requires to be justified.<sup>357</sup>

In respect of Lyons' claim regarding the hospital food policy, she said:

This case does not simply deal with a trivial aspect of everyday life. For inmates of the state hospital, the freedom to receive food parcels from visitors and to make purchases from an external source are some of the few areas in which they may exercise some sort of personal autonomy or choice. I have reached the conclusion that a person's right to choose what they eat and drink is a matter in respect of which article 8 is engaged. If that choice is interfered with, it must be justified.<sup>358</sup>

Elsewhere, the dissenting judgments of judges Tulkens, Spielmann and Laffranque in *Stanev v Bulgaria* argued that the ECtHR ought to have considered factors which contributed towards 'institutionalisation syndrome' under Article 8, in addition to considering the horrendous conditions in the Pastra Care home which contributed towards violations of Article 3.

As things stand, the ruling in *R(N)* is 'good law' in England and Wales; Lady Dorrian's *obiter* remarks, the dissenting voices of Keene LJ and the European judges in *Stanev* have no binding authority. With growing numbers of dissenting voices expressing concern about institutional rules and restrictions, one can only hope that US Supreme Court Justice Ruth Bader Ginsburg's remark that 'dissents speak to a future age' holds true.<sup>359</sup> From a republican perspective, the Court of Appeal's refusal to find Article 8 engaged by the smoking ban in *R(N)* does not bode well for use of the law to limit the arbitrary imposition of institutional rules and regimes. Furthermore, by finding that such restrictions are to be anticipated 'because of the nature of the institution', the courts have 'left unquestioned and hence reinforced' the exercise of disciplinary power within institutions, leaving such restrictions inscribed 'in the very nature of things'

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<sup>357</sup> [25]

<sup>358</sup> [26]

<sup>359</sup> This remark is widely quoted and rarely attributed. One cited source was an interview with Nina Totenberg of US station National Public Radio on 2nd May 2002.

(Golder and Fitzpatrick, 2009: 64). This ruling will directly affect psychiatric detainees, but it may have wider repercussions in other kinds of institution. Although Lord Clarke and Moses LJ distinguished psychiatric detention from care homes and private homes<sup>360</sup> the finding that smoking in itself did not warrant protection may be applied across other settings, and the reasoning may well leach into other prohibition and restrictions in everyday life. The reasoning of Lady Dorrian, which recognises that seeming ‘trivial’ freedoms like choices over food should be all the more treasured and protected for more restricted populations, is surely far to be preferred from the perspective of the problems of institutional domination.

The following example, adopted by the CQC and EHRC (2011a: 43) to illustrate Article 8 in their guidance, suggests these bodies would prefer a much lower threshold for engagement than that adopted in *R(N)*:

I remember the day I moved her in, telling the manager all the things my mum liked and disliked. She especially disliked sugar in her tea. The first time I visited, the staff were serving afternoon tea. I noticed they put two sugars in every cup. I said to the member of staff, “My mum doesn’t take sugar”, to which she replied, “It doesn’t matter – she won’t know anyway”.

The CQC and EHRC continue to describe these types of ‘everyday’ issues as engaging Article 8 – regardless of the disdainful approach of the English courts. In Chapter 5 I will describe how the CQC is in some respects better equipped than the courts to address certain kinds of pervasive and cumulative restrictions in institutional life. However, the CQC’s actions in tackling such interferences are constrained by various factors - including limited powers to inspect supported living services, and address commissioning decisions – and in enforcing such interpretations the regulator would surely benefit from the greater clarity and authority that could be afforded from a court ruling on these matters.

In the meantime, what does this mean for the MCA? Almost no published Court of Protection cases explore these aspects of institutional life through the lens of best interests. Several consider whether or not such restrictions might amount to deprivation of liberty,<sup>361</sup> but they do not test whether the restrictions themselves are justifiable with reference to mental capacity, best interests and the HRA. The issue does not appear to be that the Court of Protection is disdainful of such matters in the manner of *R(N)* – at least, they are not dismissive of it in published judgments – rather these matters seem not to be coming before the Court. This ‘silence’ on the

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<sup>360</sup> [63]

<sup>361</sup> The relationship between restrictions and deprivation of liberty is discussed in greater detail in Chapter 5.

relationship between capacity, best interests and institutionalising rules and restrictions might be a result of a number of factors linked to access to justice. These are explored at greater length in Chapter 5, but in essence people with mental disabilities will require considerable support, in particular from litigation friends, to bring litigation in the Court of Protection at all. If potential supporters share the view that such matters are ‘trivial’, are not really matters to trouble a court with, or that it is not in a person’s best interests to pursue costly, lengthy and stressful litigation for anything but the most serious welfare disputes, then potential challenges may be filtered out at an early stage. Funding such challenges may also be a problem.<sup>362</sup> Furthermore – and unlike the prisoners and restricted patients who brought analogous challenges against prison and hospital regimes – residents in care services are much less likely to be in contact with legal advisors, and to have experience of asserting their rights in court.

This suggests that despite the claims of the MCA code of practice to legislate for ‘day to day’ matters, and the hopes of the CQC (2012f) that the MCA represents a ‘promising lever’ to tackle ‘blanket rules’, they have had little traction within the machinery of the law to date. The MCA appears to have taken on a status more akin to guidance in relation to these everyday issues – there is little evidence of it being used in court by a person who is subject to some arbitrarily imposed rule to ‘invigilate’ it. There are some aspects of life within an institution which generate a flicker of legal interest, discussed below, but the question of institutional authority to impose rules and restrictions of its choosing on adults with learning disabilities lies unchallenged by law. For the moment, at least.

#### 4.6.2 CHOICE AND CONTROL OVER WHO PROVIDES CARE, AND HOW

Philosophies of self-directed support (SDS), independent living and personal assistance emphasise the importance of a person being able to choose who they are supported by, and upon what terms. This is typically contrasted with traditional models of welfare and institutional provision, whereby those commissioning and providing support services largely dictate the terms upon which a person receives support. In legal terms, mental incapacity significantly undermines the logic of SDS, independent living and personal assistance. Direct payments are a primary means by which ‘true’ personal assistance can be achieved. Yet a person who lacks the mental capacity to manage their direct payment can receive one only through a ‘suitable person’<sup>363</sup>, and it will be that person – often a family member – who will exercise choice and control over

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<sup>362</sup> More detail on public funding for litigation in the Court of Protection is provided in Appendix C, and discussed in Chapter 5. However, there is no obvious provision for these kinds of matters, unless ‘family life’ or a person’s liberty or personal safety is endangered.

<sup>363</sup> s146 Health and Social Care Act 2008

who provides care, not the service user themselves. Schwehr (2010) has expressed concern that 'personalised' care plans may 'contract out' risks to third parties where a person lacks capacity, including safeguarding risks, risks of failure to discharge community care duties effectively, and the risks of becoming an employer.

Around 24,000 adults with learning disabilities receive support through direct payments (NHS Information Centre for Health and Social Care, 2012h), but data is unavailable on the number of those which are managed by a 'suitable person'. The majority of people with learning disabilities using publicly funded services receive support through local authority arranged residential care or domiciliary care (NHS Information Centre for Health and Social Care, 2012h). As noted in Chapter 2, in such services people may experience very limited opportunities to influence employment and staff scheduling practices by the provider.

Although it represents a diminished form of choice and control in contrast with models of personal assistance, a person might still be able to *refuse* support with a particular task or from a particular person. In domiciliary care, for example, service users might refuse to allow care staff access to their property, although the legal rights of care home residents to refuse staff access to their rooms are diminished relative to domiciliary care users. Greig (2009) writes that:

In a residential care home, a person has no right to control who enters their house or personal room. They have no right to decline support from particular staff, let alone the overall provider.

Strictly speaking this will not be quite true; residential care providers are bound by regulatory standards to respect the privacy of residents.<sup>364</sup> Some residential care providers will also be public authorities in the meaning of s6 HRA<sup>365</sup>, and will be required to respect privacy in accordance with Article 8. However, I have been unable to find any evidence that Article 8 has been used in the courts to assert a 'right to be left alone' in the context of care provision. Service users would also often be able to rely upon the torts of trespass to person and property in order to refuse consent to be touched, or for their possessions to be used, for the purposes of a particular task. These are, it is acknowledged, very limited ways of exercising choice and control over who provides support and how, and often this will leave service users with a Hobson's choice of support from a person or at a time which is not of their choosing or none at all.

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<sup>364</sup> See s17(1)(a) The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 SI 2010/781. Privacy is defined by the CQC (2010c: 213) 'to recognise when they wish and need to be alone (or with family or friends), and protected from others looking at them or overhearing conversations that they might be having'.

<sup>365</sup> Where care is arranged under the National Assistance Act 1948, see s145 Health and Social Care Act 2008.

Nevertheless, a person who is deemed to lack mental capacity may not even enjoy these, diminished, rights to choice and control over who supports them, in what tasks and how. Control will be limited insofar as the MCA provides care staff with a defence for non-consensual access to one's property, to touch one's body or handle one's possessions. This passage from *G v E, A Local Authority & F*<sup>366</sup> demonstrates the extent to which a person – even a person with their own tenancy – may lose control over what support staff do on their property, to their body and possessions:

Staff at Z Road exercise what the Official Solicitor describes as complete control over E's care and movements, and over assessments, treatment, contacts and residence... [T]he concrete situation is that E is currently confined to Z Road except when he is escorted to school or on visits or activities, and has no space or possession that is private or safe from interference or examination... E is unable to maintain social contacts because of restrictions placed on access to other people, including family members, and a decision has been made by the local authority that he will not be released into the care of others, or permitted to live elsewhere, unless such a move is considered appropriate. In assessing whether he is at liberty, it is also important to note that E has been prescribed Haloperidol, a neuroleptic medication, to reduce his agitation and more challenging behaviour. He has no control over the administration of that medication.<sup>367</sup>

Clearly, E's experience of support is very far from the ideals of independent living and personal assistance – although ironically he does live in the kind of supported living service which is often taken to equate to 'independent living'. In *obiter* remarks in this case, Baker J commented that it seemed unlikely that E did hold a 'real' tenancy given that he lacked capacity to enter into any such agreement and:

...the circumstances of E's occupation preclude any tenancy ever being granted, since staff have unrestricted access to his room and provide necessary services, so that there has not been, and cannot be, any grant of exclusive possession.<sup>368</sup>

The extent to which a person's lack of capacity to agree a tenancy and inability to exclude care staff from their property were posited as factors which might render a 'supported living' service a *de facto* unregistered care home in the *Alternative Futures* cases, but this was not considered determinative by the court.<sup>369</sup>

The courts have been reluctant to find that mental incapacity renders supported living services' registration status unlawful. This is understandable, given that registration failures may be indictable criminal offences<sup>370</sup> and there are substantial

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<sup>366</sup> [2010] EWHC 621 (Fam)

<sup>367</sup> [78]

<sup>368</sup> [110], citing *Street v Mountford* [1985] AC 809 (House of Lords) on tenants' rights to exclusive possession.

<sup>369</sup> These cases are briefly touched upon in Chapter 2, see n35.

<sup>370</sup> s10 Health and Social Care Act 2008



financial gains to service users for using such services.<sup>371</sup> However, it does confirm that mental incapacity substantially limits a person's ability to exercise control over who supports them and how, as well as diminishing control over their immediate personal environment. These matters have tended to come before the courts in the context of regulators challenging a services' registration status or in considering whether or not a person is deprived of their liberty. There is little evidence of any claims being brought in the Court of Protection or by way of s7 HRA which seek to assert service users' rights to exercise greater choice and control over who supports them and how. This might be thought surprising, given how fundamental this is to the goals of the disability rights movement. One reason may be that those who would be most likely to be able to assert these rights and bring such a challenge are already able to use direct payments to achieve these ends. Consequently the common law has supplied few principles indicating how far a person using traditional care services, or with impaired mental capacity, may enjoy rights to control over their home and support arrangements which are central to ideals of independent living and personal assistance.

### 4.6.3 RESTRAINT

Given that CQC recently expressed concern about the use of restraint in 30-50% of services for people with learning disabilities (Emerson, 2012), remarkably few published Court of Protection judgments have considered its use. The use of restraint often hovers in the background for questions of whether or not a person is deprived of their liberty,<sup>372</sup> or it might be endorsed to enable the delivery of a particular intervention which the court finds is in a person's best interests.<sup>373</sup> Section 6 MCA requires that the use of restraint be proportionate, necessary and in a person's best interests – but statute and code offer scant guidance on how this should be interpreted in practice. The ruling in *ZH v The Commissioner of Police for the Metropolis* confirmed that s6 MCA had supplanted 'necessity' as a defence for the use of restraint, and reiterated that 'where practicable' would-be restrainers should consult with a person's carers and use restraint only as a last resort. However, only one published<sup>374</sup> case to date has

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<sup>371</sup> This is because whereas local authorities are under a duty to charge for people using residential care services (Department of Health, 2011a), charging is discretionary for those using domiciliary care services – as people in supported living would be – and the maximum charges which could be levied leave people with more generous allowances than for residential care (Department of Health, 2003b).

<sup>372</sup> E.g. *A Local Authority v A (A Child) & Anor*; *Surrey County Council v MEG & MIG v Anor* [2010] EWHC 785 (Fam) and *P & Q v Surrey County Council*; *G v E, A Local Authority & F*; *Re RK*; *YB v BCC* [2010] EWHC 3355 (COP); *Cheshire West and Chester Council v P & Anor* [2011] EWHC 1330 (Fam).

<sup>373</sup> E.g. *Re E (Medical treatment: Anorexia) (Rev 1)* [2012] EWHC 1639 (COP). See also *Primary Care Trust & Anor v AH & Ors* [2008] EWHC 1403 (Fam) [25]-[26].

<sup>374</sup> No doubt other cases exist; but they may not have been published.

considered a particular form of restraint in a care setting through the lens of best interests.

The decision in *C v A Local Authority (Re C)* has given some of the clearest, and best, guidance on the use of restraint in care settings. C was 18, had learning disabilities and autism, and lived in a residential school operated by the charity Scope. C often preferred not to wear any clothes, and in response to this the school had taken to confining him to a padded blue room without any toilet. His mother alleged that he would urinate and defecate and smear his faeces in the room, and that there was 'frequently an acrid and pungent smell of faecal matter in the vicinity'.<sup>375</sup> The school's psychologist regarded C's desire not to wear any clothes as difficulties understanding 'acceptable social boundaries'.<sup>376</sup> However experts instructed by the court identified that C experienced extreme haptic sensitivity and might feel 'the equivalent of neurological pain at certain times when his skin is touched and his desire to be naked is a form of tactile defensiveness'.<sup>377</sup>

Ryder J held that 'It would be unacceptable for C as an incapacitated child to be secluded or restrained without reference to best practice guidelines'.<sup>378</sup> Consequently best interests decision makers must consider best practice guidance around restraint and seclusion 'not least so as to determine whether any less restrictive options are available'.<sup>379</sup> In this particular case the expert evidence held that best practice guidance concerning seclusion was contained in the MHA 1983 code of practice (Department of Health, 2008a), a conclusion which Ryder J said 'no doubt has implications for other young people with serious learning disabilities who are in residential care'.<sup>380</sup>

Through this clever device, the sparse, flexible and ambiguous provisions of s6 MCA were coupled to much more detailed and appropriate 'best practice' guidance. Best practice guidance will, of course, differ depending upon the person and their circumstances, and it will change over time as new guidance is produced and other guidance falls out of favour.<sup>381</sup> Although best practice guidance, and even the MHA code of practice,<sup>382</sup> is not legally binding, this ruling potentially gives them much greater

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<sup>375</sup> [22]

<sup>376</sup> [75]

<sup>377</sup> [29], [77], [92]

<sup>378</sup> [71]

<sup>379</sup> [71]

<sup>380</sup> [71]

<sup>381</sup> The Department of Health are currently preparing new best practice guidance on restraint for adults with learning disabilities, the older guidance being over a decade old (Department of Health and Department for Education and Skills, 2002) and thus not making reference to the MCA.

<sup>382</sup> Bodies which detain people under the MHA must 'have regard' to the MHA code of practice, but may depart from it for cogent reasons, *R (Munjaz) v. Ashworth Hospital Authority* [2005] UKHL 58. Those bodies, such as care homes and supported living services, which do not operate MHA regimes are not obliged to have regard to the MHA code of practice.

legal force in social care settings where heretofore the use of restraint has been regulated only by the vagaries of the common law and potentially quite idiosyncratic interpretations of ‘necessity’ and ‘proportionality’ under s6 MCA.

The judgment is also interesting for displaying the complex ways in which the general defence interacts with hierarchies of responsibility and control. The case began as a judicial review against the local authority seeking a mandatory order for an appropriate care plan and damages for breach of C’s Article 3, 5 and 8 rights under the HRA. The court ruling found that C had been unlawfully deprived of his liberty by the school’s actions,<sup>383</sup> but although the school did not escape censure, Ryder J recognised that the very need to use the ‘blue room’ for seclusion arose because the local authorities’ care plan was itself inadequate. The judgment endorsed a detailed, and no doubt very costly, package of care which would provide C with a flat of his own, a closed garden area where C could be naked and a dedicated team of 15 members of staff to provide 3:1 staffing.<sup>384</sup> Recent reports suggest that C is thriving in this new environment (Irwin Mitchell Solicitors, 2012).

The case is a telling example of the relationship between the need for the use of restraint and a person’s wider social and physical environment; a finding which would be predicted by the social model of disability. This has significant implications for approaches to the meaning of deprivation of liberty, discussed in Chapter 6, which hold that a person is not deprived of their liberty if they are subject to restrictions which are the ‘inevitable corollary of his various disabilities’.<sup>385</sup> It is gratifying to see in *C v A Local Authority* a judgment that acknowledges the complex interrelationship between a person’s needs, rights and their social and physical environment.

#### 4.6.4 MEDICATION

As outlined in Chapter 2, the widespread use of sedating anti-psychotic medications to manage behaviour in care services is a live policy issue for people with mental disabilities, including people with learning disabilities. They carry significant risks to health and wellbeing, and may be used where staff lack skills in non-pharmacological support for ‘challenging behaviours’. Very often when people with mental disabilities are administered such medications in community care settings, they will be considered to lack the capacity to consent to use of such medications. In

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<sup>383</sup> The judgments makes reference to further proceedings in which the Article 3 and 8 claims would be considered, but their outcome does not appear to have been published.

<sup>384</sup> [80]-[83]

<sup>385</sup> *Cheshire West and Chester Council v P* [2011] EWCA Civ 1257 [110] see also [38]-[40] and [97].

contrast with the MHA requirements for treatment for mental disorder for people who lack capacity,<sup>386</sup> the MCA contains a dearth of procedural safeguards on their use.

Former Minister for Social Care, Paul Burstow, has expressed the view that inappropriate prescription of these medications may constitute the crime of 'wilful neglect',<sup>387</sup> and that doctors could be jailed for this (Ross, 2011). Certainly this surprising view is not borne out by any formal guidance or case law. However, given that over-use of these medications represents a very serious welfare issue and area of political anxiety, it is surprising that no cases have been brought before the courts in order to challenge their use. One reason may be that once a person is so sedated, the likelihood of their being able to object sufficiently to give rise to a challenge of any kind is reduced. This is one reason why some psychiatrists have called for the administration of such medications to be considered 'Serious Medical Treatment' requiring an IMCA referral (Branton et al, 2009).

Medications are sometimes mentioned in passing as potentially affecting a person's capacity,<sup>388</sup> or forming part of the analysis of whether or not they are deprived of their liberty,<sup>389</sup> yet whether or not their use is in a person's 'best interests' has yet to be considered in any published judgment of the Court of Protection. The ruling in *C v A Local Authority* suggests that their use must be in accordance with best practice guidance, although it is unclear what might constitute the most authoritative guidance for their use for adults with learning disabilities in community care settings. Given that the evidence suggests they often harm a person's welfare, it would be useful to have some strong guidance from the courts on when such medications are, and are not, in a person's best interests.

#### 4.6.5 PRIVACY AND SURVEILLANCE

Concerns around privacy in care settings revolve around bodily integrity, enjoyment of private spaces, private enjoyment of one's possessions, and enjoyment of relationships with others without intrusion or interference. Several of these issues have already been discussed above, and issues around contact with others outside the institution will be discussed below. One further area which deserves mention is the question of surveillance of care service users by staff. This was a defining characteristic of institutions picked up on by Goffman, and has been raised as an area of concern by regulators and institutional 'survivors'.

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<sup>386</sup> For patients detained under the MHA, treatment for mental disorder without capable consent which continues for longer than three months requires the approval of a 'Second Opinion Appointed Doctor', s58 MHA.

<sup>387</sup> Presumably he means under s44 MCA.

<sup>388</sup> E.g. *Re E (Medical treatment: Anorexia) (Rev 1)* [50]

<sup>389</sup> *G v E, A Local Authority & F*, [78]; *P & Q v Surrey County Council*, [26]

People who are deemed to lack the capacity to make decisions around risks encountered in everyday life are likely to be subject to fairly high levels of supervision within care services to ensure they do not come to harm. This is linked to the protective obligations of those providing and arranging care, discussed earlier in this chapter. Given that many people with a wide range of mental disabilities will fall into this category, human rights and mental capacity case law is remarkably silent upon this issue. There are few judgments setting out when surveillance represents an excessive interference in a person's life. The recent ruling in *J Council v GU & Ors (Rev 1)*<sup>390</sup> may, however, represent an emergent trend in that direction.

The facts of the case were fairly extreme. It concerned a man called 'George'<sup>391</sup> who was diagnosed with 'childhood autism, obsessive-compulsive disorder, dissocial personality disorder, mixed anxiety disorder and paedophilia'.<sup>392</sup> George had an unfortunate compulsion to write letters describing his fantasies of sex with children and leave them in public places, as well as other 'sexually deviant behaviour'.<sup>393</sup> As a result of George's behaviour, he was 'from time to time strip-searched... his correspondence is monitored... his telephone conversations listened to'.<sup>394</sup> These interferences, Mostyn J observed, clearly engaged George's Article 8 rights.<sup>395</sup> Mostyn then noted that 'The first requirement of Article 8 is that the curtailment must be "in accordance with the law"', which in turn meant it must have a basis in law, the legal measure must 'be accessible to the person in question' and the consequences of the legal measure must be predictable.<sup>396</sup> All of these principles are, of course, basic elements of the rule of law and republican approaches to liberty. Mostyn J went on to observe that even though the basis of permissible restrictions in national law has been interpreted remarkably liberally in the context of the MHA<sup>397</sup>, 'there are no equivalent detailed procedures and safeguards stipulated anywhere for persons detained pursuant to orders made under the Mental Capacity Act 2005'.<sup>398</sup>

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<sup>390</sup> [2012] EWHC 3531 (COP)

<sup>391</sup> In this case Mostyn J issues a welcome plea for judges to adopt names, rather than initials, to denote parties in Court of Protection litigation on the basis that cases become a confusing 'alphabet soup' for the reader and 'it dehumanises the participants' [22].

<sup>392</sup> [5]

<sup>393</sup> [6]

<sup>394</sup> [6]

<sup>395</sup> Mostyn J cites (at paragraph 9) *Wainwright v UK* (2007) 44 EHRR 40 in connection with strip searching; *Liberty v UK* (2009) 48 EHRR 1 in connection with monitoring telephone calls; *Herczegfalvy v Austria* (1992) 15 EHRR 437 in connection with monitoring correspondence; and *Nowicka v Poland* [2003] 1 FLR 417 in connection with restricting contact to others.

<sup>396</sup> [11]

<sup>397</sup> He cites (a paragraph 12) the endorsement of the court in *R (Munjaz) v Mersey Care NHS Trust* of a hospital policy which departed from the MHA code of practice as an adequate basis in national 'law' for the purposes of Article 8.

<sup>398</sup> [14]. To this one might also add – there are even fewer procedures and safeguards for any person who is subject to restrictions under the MCA, yet not detained under the DoLS.

Mostyn J went on to issue an important judgment which required a detailed policy setting out the circumstances in which George, and his room, could be searched, and his correspondence and communications monitored.<sup>399</sup> The NHS Trust was responsible for reviewing the policy on an annual basis, and scrutinising monthly reports and incident forms regarding its applications; and – perhaps most remarkably – the CQC agreed to:

‘a) Seek advice from an appropriate expert, including an expert in human rights, as to the care of George; and

b) Specifically case track George during the course of any compliance review and shall ensure that any material allegations of abuse of George at the Y Care Home are raised with the relevant safeguarding authority.<sup>400</sup>

Mostyn J went on to bemoan the lack of guidance from Parliament, the Executive or CQC for these types of restrictions, where they occur in private care homes rather than hospitals which detain patients under the MHA.<sup>401</sup>

Mostyn J’s judgment in *J Council v GU & Ors (Rev 1)* represents a truly remarkable break with the ‘informal’ approach taken to restrictions and interferences with the rights of people in community based care services under the MCA. Although the restrictions George was subject to were extreme, and for quite unusual reasons, a high level of surveillance and physical interventions are not so unusual in care services. As will be discussed in Chapter 6, debates are currently currently raging around whether those people with mental disabilities who are subject to round the clock supervision and control by care staff, frequent use of physical restraint and administration of mood-altering medication, are deprived of their liberty. The absolute dearth of detailed policy guidance on such high levels of restriction and intrusions into privacy for these people would surely engage the concerns Mostyn J outlined in connection with George. The case’s wider consequences for commissioning bodies, regulators and the Executive could be significant, and are likely to be hotly disputed.<sup>402</sup>

#### 4.6.6 INSTITUTIONAL CONTROL OVER RELATIONSHIPS WITH FAMILY AND FRIENDS

Local authorities and care services can exercise considerable control over the sexual, familial and friend relationships of care service users. Often such restrictions

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<sup>399</sup> It ultimately ran to 52 pages [17].

<sup>400</sup> [18]

<sup>401</sup> [21]

<sup>402</sup> Notably the care home and the NHS Trust, although they agreed to supply, comply with and monitor such a policy in George’s best interests, either felt that the Article 8 safeguards were unnecessary or cautioned against drawing any wider inferences [19].

are associated with deprivation of the person's liberty, although such restrictions are also regarded as having independent implications for Article 8 rights to 'establish and develop relationships with other human beings.'<sup>403</sup> The degree to which such restrictions require court authorisation, or can even be authorised under the DoLS, is as yet unclear.<sup>404</sup> Nevertheless, a comparatively large number of these cases have come before the Court of Protection and resulted in published judgments. This is an area of high activity in MCA case law.

The use of court's declarations regarding whether or not contact is in a person's best interests was carved out early on under the declaratory jurisdiction. In *Re C (Mental Patient: Contact)*<sup>405</sup> the high court made a best interests declaration that the mother of an adult who lacked capacity should permit contact with her father, where she had been obstructing it. In *Re D-R (Contact: Mentally Incapacitated Adult)* the court held that there was no presumption of a right to contact for the parent of an adult child; the court had to assess whether or not contact is in the person's best interests. In *Re F (Adult: Court's Jurisdiction)*<sup>406</sup> the Court of Appeal issued a declaration that F should have only limited contact with her family.

Following the passage of the MCA, in *Re GC*<sup>407</sup> Hedley J found that the state should not intervene in a person's enjoyment of private life unless continuance of it was clearly inconsistent with their welfare. He adopted a balance sheet approach. Later on in *A Primary Care Trust v P*, discussed above, Hedley J rejected the Primary Care Trust's (PCT) call to suspend all contact between P and his mother,<sup>408</sup> saying that would be 'a manifest breach of Article 8(1)<sup>409</sup>. However, Hedley J did set out a fairly detailed 'general approach' to contact between P and his mother, which gave guidance but did not amount to a specific order.<sup>410</sup> This guidance included the frequency<sup>411</sup> and duration of visits and phone calls from P's mother to him,<sup>412</sup> and a preference for 'light' rather than 'heavy' supervision of face to face visits,<sup>413</sup> albeit with provision to terminate visits.<sup>414</sup>

In some rare cases, such as *A Council v X*<sup>415</sup>, the court has endorsed the termination of contact between a person and their relative altogether. In *A Council v X*

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<sup>403</sup> *Niemietz v Germany*, [29]

<sup>404</sup> See the comments of Ruck Keene et al (2013: 5) regarding the case *J Council v GU & Ors (Rev 1)*.

<sup>405</sup> [1993] 1 FLR 940

<sup>406</sup> [2001] Fam. 38; [2000] 3 WLR 1740

<sup>407</sup> [2008] EWHC 3402 (Fam)

<sup>408</sup> [86]

<sup>409</sup> [59]

<sup>410</sup> [2009] EW Misc 10 (EWCOP); [2009] CoPLR Con Vol 956 [88]

<sup>411</sup> [83]

<sup>412</sup> [82]

<sup>413</sup> [84]

<sup>414</sup> [86]

<sup>415</sup> [2010] EWHC B10 (COP)

the court emphasised that practical obstacles, such as finding a neutral location where visits could take place, should not be a barrier to contact. However, in that case it was held not to be in Y's best interests to have contact with her daughter as she no longer recognised her, and the daughter was said to be unable 'to contain herself, even for an hour, without the risk of her becoming confrontational or abusive'.<sup>416</sup> Termination of contact between a person and their relative without considering whether or not supervised contact could be permitted, or where a provider or authority have been guided solely by the wishes of capacitous relatives and not come to an independent considered view of a person's best interests, is likely to violate the person's Article 8 rights. In *City of Sunderland v MM & Ors*<sup>417</sup> the court found that this breached not only the rights of the person who lacked capacity, but also of a partner who was prevented by a care home from visiting her for two years.

Usually public authorities seek to limit or terminate contact on the basis of 'safeguarding' allegations. A question therefore arises as to how well evidenced such allegations must be for the Court of Protection to endorse such significant interferences in people's Article 8 rights. In *LBB v JM, BK and CM*<sup>418</sup> the local authority took the view that an intervention, which might potentially breach Article 8, would require the factual basis of concerns to be established - an approach which Hedley J 'broadly' endorsed.<sup>419</sup> However, he noted that the MCA did not include 'threshold' provisions equivalent to those under the Children Act 1989, and - as they were not intended by parliament - these should not be imported by the court. Nevertheless, he held that 'if there is a contested factual basis it may often be right... that that should be investigated and determined by the court.'<sup>420</sup> Barristers Ruck Keene, Butler-Cole, Norris and Allen (2012b: 97) observe that:

...it can be easy for a local authority to assume that a history of suspicious incidents and safeguarding alerts will translate easily into declarations restricting or banning contact, when in reality the process is much more complicated.

However, as DJ Marin observed in *WCC v GS, RS and J*<sup>421</sup> fact finding hearings can be lengthy, 'eat up the court's pressed resources' and are expensive in terms of the time of social workers and professionals who must give evidence to the court.<sup>422</sup> For example, the case *HN v FL and Hampshire CC*<sup>423</sup> resulted in a four day fact-finding hearing. Although *LBB v JM, BK and CM* appeared to suggest that the court's

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<sup>416</sup> [41]

<sup>417</sup> [2009] CoPLR Con Vol 881

<sup>418</sup> [2010] CoPLR Con Vol 779

<sup>419</sup> [7]

<sup>420</sup> [8]

<sup>421</sup> [2011] EWHC 2244 (COP)

<sup>422</sup> [31]

<sup>423</sup> [2011] EWHC 2894 (COP)



intervention might be necessary for such cases, the above cited barristers note that in their 'collective experience of numerous cases' the courts often took a more 'pragmatic approach' (p113).

Published cases concerning restrictions on contact with sexual partners are markedly less numerous than those relating to family members. They have typically arisen where a person is regarded to lack the capacity to consent to sex – a complex and contested test, discussed above – and where public authorities have therefore sought to prevent that person from having sexual relations with others. As noted earlier, in *D Borough Council v AB* and *A Local Authority v H* adults with learning disabilities who were said to lack the capacity to consent to sex were deprived of their liberty by care regimes designed to prevent them from having sexual relations. It is never explicitly discussed in these judgments *why* a local authority and care provider must take active steps to prevent a person from having sexual relations where they lack capacity to consent to it. It might be thought obvious that they should, given that sex with a person who lacks capacity to consent to it is a criminal offence.<sup>424</sup> Such reasoning is never made explicit in these cases, and there is no authority establishing a positive obligation to prevent sexual relations with a person who lacks mental capacity. Nevertheless, it would be surprising if a court found that it was not in their best interests to prevent them from being the victim of a sexual offence, but it might also be thought a surprising outcome to deprive a person of their liberty in order to prevent them from becoming the victim of a crime.

It is possible that a person may pass the test of capacity to consent to sex, which is deliberately engineered to set a comparatively low threshold,<sup>425</sup> yet be considered to lack the mental capacity to make decisions around contact with a person. The case *Local Authority X v MM and KM*, discussed earlier in the context of positive obligations to make available resources to support a person's sexual relationship, was one such case. The case is precedent for a person who has the capacity to consent to sex having a right arising under Article 8 to be supported in continuing a sexual relationship, even if contact with the sexual partner is closely controlled by those arranging and providing their care.

*LB Hammersmith and Fulham v MW (Re MW)* appears to be the sole published case (to date) considering a person's capacity to consent to contact with a friend. In that case the local authority sought an injunction prohibiting JC from visiting his childhood friend, MW, at home. MW had a diagnosis of a 'borderline mental impairment' and a schizoaffective disorder.<sup>426</sup> He had previously been detained under the MHA and was currently under restriction and supervision on a Home Office

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<sup>424</sup> s27(1)(b) MCA

<sup>425</sup> See earlier discussion in section on 'What must be understood' for capacity assessments.

<sup>426</sup> [7]

license<sup>427</sup> for an index offence of stabbing an elderly couple.<sup>428</sup> He had been discharged from hospital in the past but had been readmitted following ‘irregularities’ in his attendance at a day centre which was associated with JC being in his house.<sup>429</sup> A tribunal later discharged him on condition that an injunction be sought which would prevent JC from visiting MW.<sup>430</sup> The basis for this seems primarily to have been general suspicions, held by MW’s doctors, that JC was a bad influence on MW, joining him in spending lots of money and raising concerns about MW’s lithium regime which was regarded as jeopardising MW’s compliance with it. The judgment is strikingly paternalistic in tone and deferent to medical opinion regarding JC’s bad influence and rejecting his concerns about the medication.

Notably the judge in *Re MW* does not go to the considerable lengths to establish the concerns of the doctors on a factual basis, as occurred in many cases concerning contact with families, nor was Article 8 mentioned at any point in the judgment. This is disappointing, as invoking Article 8 would have shifted the court’s attention to how proportionate the order was, and whether a companion order could have been made requiring MW’s relationship with JC to be supported in other ways, rather than the court merely ‘hoping’<sup>431</sup> it would continue. One wonders whether a case would have been brought to court at all seeking judicial authority to restrict contact between friends had it not been a specific requirement of the tribunal, and had JC not been a man clearly capable of opposing the order. Where care providers and authorities take a dubious view of more fragile friendships, which require support to maintain and where those friends are unlikely to be able to challenge such restrictions themselves, one wonders whether an application to court to consider the issues would be made at all. On the basis of the rather shallow treatment of human rights and friendship in *Re MW*, and the scarcity of such cases, one suspects that actively imposed restrictions on friendships and failures to support their maintenance may be an area where providers and authorities enjoy considerable unconstrained and unscrutinised discretion.

#### 4.7 DISCUSSION: BEST INTERESTS AND INSTITUTIONAL LIFE

This analysis of capacity and best interests case law shows that far from providing leverage against ‘institutionalising’ practices, the MCA may in fact precipitate and facilitate them in several respects. The test of capacity introduced by the MCA is in itself an interference, and a relatively unconstrained one at that. Public authorities

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<sup>427</sup> [10]

<sup>428</sup> [9]

<sup>429</sup> [18]

<sup>430</sup> [23]

<sup>431</sup> [67]

and care providers operate in a climate of tremendous uncertainty regarding the extent of their obligations to protect people who may lack capacity from harmful choices. This may, as Baker J noted in *CC v KK*, lead to the MCA being used in a risk averse fashion to override 'unwise' decisions which might result in some harm befalling a person. This 'protection imperative' can be regarded as prompting a range of interferences, from surveillance of a person's everyday activities, the erosion of their rights to bodily integrity and exclusive possession of their properties, through to the decision to place a person in 'institutional' services in the first place. The MCA, through its interrelationship with public law powers to provide services, creates a facility to slide people into institutional services in their best interests. This mechanism has almost none of the checks and balances associated with formalised approaches to substituted decision making such as detention and guardianship.<sup>432</sup>

Once in those care services people with learning disabilities may find it very difficult to leave them should they wish to do so. This is in part because it requires public authorities to make available alternative placements using their public law powers, and in part because it remains subject to their demonstrating the capacity to make such a decision. In republican terms, this places them in a relationship of dependency with very high exit costs; a necessary (but insufficient) ingredient of domination. In Chapter 2 I outlined evidence that within those services people with learning disabilities experienced considerable arbitrary interferences by institutional authorities with their everyday choices and freedoms; I called this 'institutional domination'. In this chapter I showed that the courts had provided few clear and well known principles to constrain such interferences.

There are considerable uncertainties in how capacity should be assessed, leaving capacity assessors able to use the test in flexible and arbitrary ways. This is no critique of assessors themselves; where the courts and the code have delivered conflicting and contradictory guidance – if they have provided guidance at all - they can do little else but, as a collective, apply it arbitrarily. In a climate of such uncertainty over the distinction between an unwise decision and an incapacitous one, who can blame assessors if they often opt for the risk averse option?

For the vast majority of issues raised in the disability rights, regulatory and policy literature, summarised in Chapter 2, the courts have offered limited, or inadequate, principles for permissible interferences. This is especially so for institutional rules and regimes and the use of sedating medications, issues which are

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<sup>432</sup> Although, I do not mean to imply that guardianship as it is widely used in other jurisdictions is an acceptable way to place a person in an institution either. The recent crop of cases concerning deprivation of legal capacity before the ECtHR, discussed in Chapter 5, show that once a person is subject to guardianship there are very few means of attracting scrutiny to their treatment, or challenging institutional confinement.

well established areas of concern. However, there are some potentially promising seeds of change. A growing number of dissenting judgments from a variety of sources have expressed dissatisfaction with judicial efforts to retract scrutiny from institutionalising practices. *CC v KK* has led the way in providing more detailed guidance on how capacity assessment should be approached, although more would be welcome. The ruling of Mostyn J in *J Council v GU & Ors (Rev 1)* neatly encapsulates the precise concerns which animate this thesis: that users of community care services are subject to quite considerable interferences with their privacy and liberty, interferences for which there is a dearth of policy or legal guidance and safeguards. The case may have more radical implications than has, perhaps, yet been appreciated. The ruling in *C v A Local Authority* established a neat mechanism whereby – should the Executive feel minded to produce appropriate guidance on the concerns discussed here – they could be given greater legal force through the MCA.

By way of contrast, the Court of Protection has been very busy expanding guidance around the right to family life – in connection with questions of whether a person should live with their family or not, and matters relating to contact with family members. Clearly this is an important area where detailed guidance is desirable. However, this does stand in striking contrast with the dearth of case law concerning restrictions which do not involve family members. This may reflect a number of factors. One might be the funding priorities of the Legal Services Commission.<sup>433</sup> Another, the comparatively well established use Article 8 can be put to in relation to family life in contrast with somewhat more embryonic rights to development of personality (Krajewska, 2011) and freedom from institutionalisation. However, it may also reflect the increased likelihood that public authorities and families will use the court when they come into conflict with each other, as opposed to when they come into conflict with people with disabilities alone.

Family carers of people with learning disabilities are not a group who are typically regarded as ‘powerful’ in society. However, relative to people with learning disabilities themselves they are much better equipped to challenge the exercise of power by public authorities and providers. This means that on the one hand, families – although they do experience formidable difficulties accessing justice – are still more likely to be able to bring a challenge against a public authority than people with disabilities would be able to without family support. On the other hand, knowing this, public authorities may be more likely to apply to court themselves where they are in conflict with family members. Furthermore, in many of the cases concerning contact public authorities seek to make use of injunctions against family members which are

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<sup>433</sup> This is touched upon in Chapter 5, and a more detailed summary of the availability of legal aid for Court of Protection litigation as of late 2012 is given in Appendix B.

only available through the courts. This means that although the overall numbers of people bringing welfare disputes and conflicts to court is low,<sup>434</sup> those that are getting there are typically disputes between families and professionals.

Mladenov (2012: 2) and others have observed that groups with greater economic, social and cultural power 'are more likely to influence interpretation [of the law], to "bend" it in accordance with their own positions'. Consequently the law's development is skewed towards the interests of those who are better able to access its machinery (Brown, W., 2002; Russell, 2002; Rose, 1985). There may be a strong relationship between the access to justice issues outlined in Chapters 5 and 6, and the fact contact is a relatively well developed area of MCA case law whilst other areas of concern rarely seem to be contested using the Act.

Disappointingly, this means that at present the MCA cannot be said to adequately constrain arbitrary interferences in care settings in order to address the problems of institutional domination discussed in Chapter 2. However the MCA, especially in combination with the HRA, has provided a means by which such issues might be brought to the attention of the courts and so these issues may be addressed in the future. The MCA is a step on a journey through which the law is becoming better acquainted with the issues which have faced a population who have hitherto been silent, but it is early days yet.

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<sup>434</sup> This is discussed in more detail in Chapter 5.



# CHAPTER 5 – ENFORCEMENT OF THE MENTAL CAPACITY ACT 2005

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## 5.1 INTRODUCTION

The regulatory and research literature has shown that people with learning disabilities who live in health and social care institutions are at risk of wide ranging interferences with their privacy, choices and freedoms in everyday life. Republicans identify the exercise of arbitrary power with ‘domination’, and domination by those commissioning and providing institutional care is called ‘institutional domination’ in this thesis. The republican prescription for ameliorating states of domination is to provide clear and well known principles defining when interferences are acceptable. However, republicans also maintain that ‘mere normative standards’ are insufficient to ameliorate states of domination – they must be ‘meaningfully backed by some sort of enforcement mechanism’ (Lovett, 2010a: 97). Republicans often cite appeals to courts and tribunals, but standards can also be enforced in other ways (Ferejohn, 2001; Lovett, 2010a: 100, 107). Whilst acknowledging that compliance with the Mental Capacity Act 2005 (MCA) may be promoted through a variety of means, not least through ‘legal consciousness’ (Silbey, 2008) and organisational processes, this chapter focuses on four key mechanisms of enforcement of the MCA. These are:

1. Independent Mental Capacity Advocates (IMCAs)
2. The Court of Protection
3. The Local Government Ombudsman (LGO)
4. The Care Quality Commission (CQC)

One reason for selecting these mechanisms, and not modes of constraint that are internal to the individuals and organisations exercising power, is that republicans emphasise that ‘effective constraints must be external to the power-wielding persons or groups themselves’ (Lovett, 2010a: 100). Another reason is that all four are cited in the MCA code of practice as means of resolving disagreements and disputes (Lord Chancellor's Office, 2007: Chapter 15).<sup>435</sup>

For republicans, the key questions to ask of these mechanisms are whether they are independent, and whether they are effective in reigning in the inappropriate exercise of power in accordance with the MCA. I have already argued in Chapter 4 that there remain considerable uncertainties regarding how power should be exercised

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<sup>435</sup> See Chapter 3, section entitled ‘3.3 Mechanisms enforcing the principles of the Mental Capacity Act 2005’ for further discussion.

under the MCA in relation to the test of mental capacity and various interferences associated with institutional domination. Nevertheless, independent and effective mechanisms of enforcement are still of importance as a way of bringing these uncertainties to light. In the words of Fennell (1986: 59), they can 'open up areas of the ...system to scrutiny which might otherwise remain hidden, and they require those who operate the system to reflect on and justify what they are doing'.

Republican discussion of how such methods of enforcement might work is rather scant, and there is a large critical literature – reviewed in Chapter 2 – which explores the shortcomings of the 'turn to law' as a means for tackling oppression. Particular concern was expressed as to how far oppressed groups are actually able to use the law to pursue their own concerns, meaning that those cases which actually reach the courts are not representative and thus law is more responsive to the concerns of more powerful groups (Brown, 1995; Rose, 1985). It is suggested that the relatively large number of cases concerning conflicts between public authorities and family members, in contrast with cases about other aspects of institutional domination, is evidence of this occurring in the Court of Protection. Another area of concern was the 'bureaucratic domination' (Brown, 1995: 121, fn 41) that people might experience whilst trying to assert their rights using the law. To put this into republican language, just because a mechanism of enforcement exists, does not mean people are actually, in practice, reliably able to use it to 'invigilate' arbitrary interferences with their interests (Pettit, 2008b).

These criticisms of the 'turn to law' to constrain arbitrary power are acknowledged, and as I will show in this chapter they are clearly visible in many modes of enforcement of the MCA. Nevertheless, as Lobel (2006) writes, for as long as law exists and exercises social influence it would be unfortunate if reformers turned away from legal strategies, or they will simply develop without their input. Instead, it is important to look at the minutiae of those mechanisms which contribute towards the very concerns expressed by the critics of the 'turn to law', to see if we can suggest improvements or alterations which could reduce its disempowering and dominating effects.

This chapter draws upon a detailed study of the available research and grey literature for each of these mechanisms, in addition to relevant doctrinal materials. These findings are supplemented by requests made under the Freedom of Information Act 2000 (FOIA) and interviews with legal, health and social care practitioners working in the field. Several micro-studies examining particular aspects of enforcement mechanisms were also conducted, but are not described in any great detail in the body of this thesis. Details of micro-studies into regulatory and soft-law mechanisms are



given in Appendix B, and more detailed statistical and technical information about legal activity connected with the MCA is presented in Appendix C.

## 5.2 THE EFFICACY OF INDEPENDENT MENTAL CAPACITY ADVOCATES IN ENFORCING THE MCA

### 5.2.1 THE ORIGINS OF THE IMCA SERVICE

During the later stages of the MCA's passage from the Law Commission's (1995) proposals onto the statute books, civil society groups became increasingly concerned that the 'general defence' of s5-6 MCA afforded health and social care practitioners considerable scope to make major decisions about medical treatment and placement in care services with very few checks and balances. The Making Decisions Alliance (2003: [5d.14]) expressed concern that the Bill did not contain 'sufficient mechanisms to ensure that [its] principles are implemented in practice', observing that:

...the draft Bill currently lacks any accessible mechanisms by which an individual may challenge a formal or informal assessment of capacity made about them. Although an individual assessed as lacking capacity can make an application to the Court of Protection to challenge any declaration made by the Court on the basis of this assessment ...the Bill does not explain how Ministers envisage that a person who may have a significant mental disorder can be supported to make such an application.

Concern that the 'general authority'<sup>436</sup> contained insufficient safeguards was shared by many respondents to the consultation on the Draft Mental Incapacity Bill, including Mencap, the Alzheimer's Society, the Law Society, the British Association of Social Workers, People First<sup>437</sup>, the British Psychological Society, the Disability Rights Commission, the National Autistic Society, Age Concern and others (Joint Committee on the Draft Mental Incapacity Bill, 2002-3).

The MDA recommended that the Bill make statutory provision for independent advocacy services to help ensure that 'the needs and rights of the individual remain at the forefront of this Bill and that its overarching principles are fulfilled' (Making Decisions Alliance, 2003: [5b]). In response, the Mental Capacity Bill laid before parliament in 2004 included provision for 'independent consultees' for 'particularly vulnerable people and situations' (Department for Constitutional Affairs, 2004: R92;

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<sup>436</sup> This was later renamed the 'general defence' by the government, as it gave 'rise to concerns that the General Authority would allow too much licence to intervene in the lives of people who may lack capacity' (Department for Constitutional Affairs, 2004). It is unclear how the government thought that renaming the provision without changing its core legal structure would reduce the scope for intervening in the lives of people who may lack mental capacity.

<sup>437</sup> A self-advocacy organisation, advocating for people with learning disabilities.

Department of Health, 2005c; b; 2006b; e). These 'independent consultees' eventually became Independent Mental Capacity Advocates (IMCA's), created by ss35-41 MCA.

## 5.2.2 THE IMCA ROLE

The IMCA role is defined by statute<sup>438</sup> and regulations<sup>439</sup>. Local authorities are charged with 'making arrangements' so that IMCA services are available in their area<sup>440</sup>, using funds allocated from the Department of Health (2006e). A referral to an IMCA must be made where a person is considered to lack mental capacity in relation to a particular decision, and the relevant body is satisfied that they have no family or friends whom it would be appropriate to consult in determining what would be in their best interests, in the following circumstances:

- Where an NHS body is proposing to provide serious medical treatment for a person,<sup>441</sup>
- Where an NHS body<sup>442</sup> or local authority<sup>443</sup> is proposing to arrange accommodation in a hospital for longer than 28 days or care home for longer than 8 weeks;
- The role was later expanded to allow NHS bodies or local authorities to instruct an IMCA if they 'are satisfied, that it would be of particular benefit to P to be so represented' for reviews of care plans or in adult protection cases.<sup>444</sup>
- There are also specific IMCA roles in relation to the DoLS, these are discussed in Chapter 6.

Once instructed by a decision maker, IMCAs have a variety of tasks directed towards 'how best to represent and support P'<sup>445</sup>. A major part of their role is gathering information connected to best interests decisions.<sup>446</sup> They must 'to the extent that it is

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<sup>438</sup> s35-41 MCA

<sup>439</sup> The Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (General) Regulations 2006 SI 2006/1832; The Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (Expansion of Role) Regulations 2006 SI 2006/2883

<sup>440</sup> Under s35(1) MCA the 'appropriate authority' is the Secretary of State for Health in England and the Welsh National Assembly for Wales. In England, the Secretary of State for Health has issued The Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (General) Regulations 2006 SI 2006/1832, which require IMCA appointments to be approved by local authorities.

<sup>441</sup> s37 MCA

<sup>442</sup> s38 MCA

<sup>443</sup> s39 MCA

<sup>444</sup> The Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (Expansion of Role) Regulations 2006 SI 2006/2883

<sup>445</sup> r6 The Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (General) Regulations 2006 SI 2006/1832

<sup>446</sup> IMCAs must 'take all practicable steps to obtain such other information about P, or the act or decision that is proposed in relation to P, as the IMCA considers necessary' (r6(4)(d) The

practicable and appropriate to do so', interview 'P', examine records relevant to P<sup>447</sup> and consult with 'persons engaged in providing care or treatment for P in a professional capacity or for remuneration' and any 'other persons who may be in a position to comment on P's wishes, feelings, beliefs or values'. The IMCA must then evaluate all this information and ascertain 'the extent of the support provided to P to enable him to participate in making any decision about the matter'. IMCAs must also ascertain what his 'wishes and feelings would be likely to be and any beliefs and values that would be likely to influence [him] if he had capacity in relation to the proposed act or decision', what alternative courses of action are available to a person, and for medical treatments must ascertain whether a further medical opinion would be likely to benefit the person. The IMCA must then prepare a report for the person who instructed him, and include in it 'such submissions as he considers appropriate in relation to P and the act or decision which is proposed in relation to him'.<sup>448</sup>

Redley et al (2009: 4) describe the primary responsibility of IMCAs as 'to ensure that the substitute decision-maker gives due regard to the person's wishes, beliefs and values, including any relevant wishes expressed prior to the decision'. When asked how the decision process might differ if IMCA's were not present, IMCAs interviewed for this research responded that 'Too many assumptions would be made about people because of their condition or age', and that there was a danger that the person at the centre of the decision might disappear. They understood their role as being to affirm their personhood in what could be a depersonalising process: 'this is *Ruth*, this is *Eleanor*'.

Many of IMCAs' duties to consult, consider and include are also shared by best interests decision makers under s4 MCA; part of their role therefore appears to be 'outsourcing' these relational tasks from decision makers. In interviews for this research, IMCAs noted that decision-makers often did not have enough time to get to know a person and consult with people, and increasingly tended to leave it to IMCAs, who had built up a reputation of being skilled in this area. IMCAs interviewed for this research also stressed the importance of non-verbal communication in getting to know their clients, and their strong links to speech and language therapy services. Townsley and Laing (2011) found that IMCAs often brought additional communication skills to decision making processes (see also Lee-Foster, 2010). They also found that in some cases, the support of an IMCA could elevate a person above the threshold of the test of

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Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (General) Regulations 2006 SI 2006/1832).

<sup>447</sup> IMCAs have powers to access P's medical, local authority social services and care provider records 'which the person holding the record considers may be relevant to the independent mental capacity advocate's investigation' under s35(6) MCA.

<sup>448</sup> r6 The Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (General) Regulations 2006 SI 2006/1832

mental capacity, although their role is not – technically – to enable a person to attain capacity.

Although IMCAs were introduced in response to concerns that there were no monitoring arrangements or accessible means of challenging decisions made under the MCA (Making Decisions Alliance, 2003), IMCAs are not formally required to monitor or challenge mental capacity assessments or best interests decisions. Their role, as defined in the statute and regulations, is primarily to provide information for decision makers. They do have ‘the same rights to challenge the decision as he would have if he were a person... engaged in caring for P or interested in his welfare’,<sup>449</sup> but outside of the specific context of the DoLS<sup>450</sup> they have no explicit duties to do so. No government guidance is provided to help IMCAs identify when it would be appropriate to challenge mental capacity assessments or best interests decisions, either on behalf of their client or where they themselves have concerns. There is, as yet, no case law that clarifies this. This places considerable discretion in the hands of individual IMCAs as to how far they challenge departure from the principles of the MCA. This injects an element of arbitrariness into the functioning of the IMCA service as a safeguard in itself.

## 5.2.3 THE IMCA SERVICE IN PRACTICE

### REFERRALS

IMCA’s can only function as a safeguard for decisions where there has been a referral. However, there has been a considerable shortfall between the number of IMCA referrals anticipated by the Department of Health and the actual number of referrals made.<sup>451</sup> Even by the fourth year of the IMCA service, and with the IMCA role being significantly expanded<sup>452</sup>, the total number of IMCA referrals had not reached 70% of the demand anticipated by the initial impact assessment (Department of Health, 2006e). The Department of Health also reported large variations in the number of referrals between different geographical areas, which could not be explained by population size. The Department commented that ‘The duty to refer people who are eligible to IMCAs is still not understood in all parts of the health and social care sector’,

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<sup>449</sup> r7 The Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (General) Regulations 2006 SI 2006/1832

<sup>450</sup> Section 39D(7)-(9) MCA require IMCAs to assist a detainee or representative they have been referred to represent with exercising any ‘relevant rights’ of appeal or review under the DoLS. These provisions are discussed in Chapter 6.

<sup>451</sup> The Department of Health anticipated that there would be 16,000 decisions requiring an IMCA referral in the first year. Data collected annually by the Department of Health (2008c; 2009c; 2010d; 2011b) revealed that the number of IMCA referrals in the first year of the service reached only 32% of estimated demand. See Appendix C for a more detailed breakdown of the number of IMCA referrals in the first four years of the IMCA service.

<sup>452</sup> By the deprivation of liberty safeguards (s39 MCA) and The Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (Expansion of Role) Regulations 2006 SI 2006/2883.

and consequently 'many vulnerable people without family or friends to represent them ...may not be being referred to an IMCA for support for critical decisions which they lack capacity to make themselves' (Department of Health, 2011b: 5-6). The Social Care Institute for Excellence (2010: 8) has also expressed concern about the low referral rates to IMCAs for care reviews<sup>453</sup>, and questions whether 'all possible support is being provided to people to participate when care reviews are arranged'.

It is unclear exactly why IMCA referral rates are still so low. As the Department of Health suggests, a lack of awareness and understanding of the role may be part of the problem. IMCAs interviewed for this research found that awareness of their role varied among decision makers, for example they observed that whilst social workers tended to be fairly well aware of the IMCA role, GPs tended not to be. Low referral rates might also relate to attitudes of decision makers towards IMCAs. Redley et al (2009: 10) found a degree of scepticism among medical professionals around the role of IMCAs in serious medical treatment decisions, having 'doubts about the contribution that could be made by anyone without medical training' and regarding advocacy as 'unnecessary, since, as health care practitioners, they themselves already acted in the best interests of their patient'. IMCAs interviewed for this research also reflected upon issues of their status with other professionals, commenting that whilst they were mostly seen as helpful they were sometimes seen 'as an irrelevance and sometimes as a nuisance'. They expressed frustration at lacking 'clout' as a result of sitting in the third sector rather than, for example, being embedded in a hospital. It seems possible, therefore, that even though best interests decision makers are statutorily required to make IMCA referrals, scepticism about their role and their 'outsider' status within professional and service hierarchies may contribute to low levels of referrals.

One final – and perhaps obvious – reason for low levels of referrals to IMCA services may be that IMCAs are a source of scrutiny and potential challenge for decision makers. It is inherently problematic that referrals for IMCAs must come from decision makers themselves if they are to act as a robust safeguard to ensure their decisions follow the principles of the MCA. For those who are aware of their statutory duty to refer to an IMCA, there is still considerable scope for flexible judgments as to who is 'befriended' or 'unbefriended', and which medical treatments are sufficiently 'serious', to warrant an IMCA referral. Meanwhile those who are unaware of their statutory duties to instruct IMCAs are also likely to be the decision makers we should be most concerned about, being unaware of the requirements of the MCA. For an unbefriended person, the prospects of sanction against decision makers for failure to

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<sup>453</sup> As per r5 The Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (Expansion of Role) Regulations 2006 SI 2006/2883

make an IMCA referral is extremely low,<sup>454</sup> and it is difficult to see what realistic sources of pressure there are to comply with IMCA referral duties.

The key problem with the referral mechanism is that those who have the least understanding of the MCA, those who are least in tune with its values of including and supporting a person to participate in decisions, or those who seek to avoid any external scrutiny and possible challenges to their decisions, are among the least likely to make an IMCA referral at a time when it might be most beneficial. And yet, it is difficult to see how else the need for a referral for such a decision-specific form of advocacy could be flagged up. This is one argument in favour of provision for longer term support from advocates.

## COMPLAINTS

The Department of Health (2006e: [5.11]) envisaged that 'IMCAs will use existing complaints mechanisms to resolve disputes locally as far as possible when these arise about a decision made by an NHS body or local authority, or about the process that has been followed in reaching a decision, in relation to a person who lacks capacity'.<sup>455</sup> Townsley and Laing (2011: 33) found that IMCAs sometimes 'queried the judgement about the lack of capacity of the client concerned' which led to a person's mental capacity being reassessed. However, according to data published by the Department of Health (2010d; 2011b), only around 0.12-0.14% of IMCA referrals have resulted in a formal complaint of some kind, and 0.04-0.07% in an application to the Court of Protection.<sup>456</sup> During the consultations on the IMCA service, respondents 'were clear that a fundamental part of the IMCA role was to be able to challenge the original decision that the person lacks capacity' (Department of Health, 2005b: [70]), yet it appears that in practice this is very rarely happening.

There are a number of possible reasons for the very low number of reported challenges initiated by IMCAs. The Department of Health (2011b: 28-9) suggested that these low figures may simply reflect recording errors, but there have been few signs of improvement over the years. In their research, Townsley and Laing report no evidence of IMCAs initiating applications to the Court of Protection.<sup>457</sup> Two of the three IMCAs I

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<sup>454</sup> To the best of my knowledge, the only court case in which a public authority has been criticised for failure to refer to an IMCA when they should was *London Borough of Hillingdon v Neary & Anor*, [194], [197]

<sup>455</sup> The MCA code of practice guidance on IMCAs also recommends using complaints processes (Lord Chancellor's Office, 2007: [10.34])

<sup>456</sup> See section 'C5 Independent Mental Capacity Advocacy Service' in Appendix C for a more detailed breakdown of complaints instigated by IMCAs, from which these percentages are calculated.

<sup>457</sup> Townsley confirms that 'there are no examples given by any of the IMCAs involved in the research of referring to the Court of Protection' in the raw data for the research (personal communication, 4 October 2011). The research surveyed 23 IMCAs, interviewed 9 and covered 151 cases. It took place shortly after the DoLS had been introduced.

interviewed had never initiated an application to the Court of Protection.<sup>458</sup> Data supplied by the Court of Protection suggests that IMCAs have initiated applications under the DoLS on a very small number of occasions (FOIA #15).<sup>459</sup>

IMCAs may also be reluctant to challenge as a result of tensions in relationships with decision makers, who are responsible both for instructing them in the first place and granting access to much of the information they require to fulfil their role. Two of the IMCAs interviewed for this research said they were more likely to be seen as an 'irrelevance' or 'nuisance' 'if we question too hard or uphold the views and wishes of the person when these do not accord with the DM's preferred course of action'. They observed that past conflicts could impinge on future working relationships which had taken a long time to build up, and so they tried not to go in confrontationally. If 'conflict is on the horizon', they would give indications early on if there was the potential that they might challenge a decision. These practices might neutralise some potential disputes earlier on, which might offer a partial account of the low number of challenges. However it does also seem possible that concern with maintaining working relationships could have a chilling effect on challenging decision makers too assertively on behalf of their clients. Redley et al (2009: 12) also describe the 'considerable tension' IMCAs experienced between 'their responsibility to clients and the need to develop and maintain constructive relationships with decision-makers'. They connected this with reluctance by IMCAs to make formal challenges.

Another factor discouraging IMCAs from making formal complaints could be a lack of time and resources. 'Complex' IMCA referrals were estimated to require only eight hours of their time (Department of Health, 2006e). IMCAs interviewed for this research described operating under considerable time pressure, echoing other research findings (Redley, Marcus et al., 2009; Townsley and Laing, 2011). Furthermore, if IMCAs apply to the Court of Protection themselves, they will receive no specific reimbursement for the costs of applications and legal advice and representation. Although, the resources allocated to local authorities to commission IMCA services by the Department of Health (2006e: [5.11]) contained additional funds to cover disputes, including 'where an IMCA takes a case to Court', the funding is not ring-fenced (Department of Health, 2008d).

However, the MCA code of practice does not seem to envisage IMCAs applying to the Court of Protection in their own right where they have concerns. It guides IMCAs

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<sup>458</sup> The third IMCA I interviewed had been involved in Court of Protection litigation in connection with a referral under the DoLS. IMCA's duties under the DoLS are different, however, and will be discussed in Chapter 5.

<sup>459</sup> The role of IMCAs in applying to the Court of Protection under the DoLS is legally distinct from their role in non-DoLS cases, and will be discussed in Chapter 5. The limited data the Court of Protection were able to share with me on the identity of applicants for DoLS appeals is given in Table 15, Appendix C.

to approach the OS<sup>460</sup> as the 'first step in making a formal challenge' (Lord Chancellor's Office, 2007: [10.38]).<sup>461</sup> If the OS declines to bring a challenge on a person's behalf, the code of practice suggests that IMCAs apply to court themselves to be appointed as the person's litigation friend. As yet there have been no published judgments where an IMCA has acted as a litigation friend in the Court of Protection.<sup>462</sup> As a litigation friend the legal costs (aside from the initial application free) would be borne by the person themselves or any public funding they are eligible for.<sup>463</sup> Guidance for IMCA services rather unhelpfully suggests that 'the responsible body [may seek] to recover their costs from the IMCA service'<sup>464</sup> (Social Care Institute for Excellence, 2010: 10), without highlighting the Court of Protection's 'general rule' that a 'losing' party would not be awarded costs in personal welfare cases.<sup>465</sup>

To what extent should we be concerned about the low volume of formal complaints and applications to the Court of Protection by IMCAs? On the one hand this may reflect the success of informal dispute resolution processes, an approach emphasised by the MCA code of practice (Lord Chancellor's Office, 2007: [10.35]-[10.36]) and by IMCAs themselves in interviews for this research. It might also be observed that the number of applications to the Court of Protection for health and welfare matters is generally low anyway,<sup>466</sup> even in respect of people who are 'befriended' and do not have an IMCA to support them. Yet this may simply tell us that neither IMCAs nor family and friends are regularly accessing the Court of Protection to challenge health and welfare decisions made by professionals.

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<sup>460</sup> The role of the Official Solicitor as a litigation friend in the Court of Protection will be described in more detail below.

<sup>461</sup> This advice is also given in early guidance issued by Turning Point (2006).

<sup>462</sup> In *AB v LCC (A Local Authority)* [2011] EWHC 3151 (COP), a case connected with the DoLS, Mostyn J appointed a paid representative to be a litigation friend, and paid representatives are very often provided by IMCA services and may have acted as an IMCA earlier in that case or in other cases. However, strictly speaking a paid representative is not an IMCA and their role is distinct. One critical difference is that IMCAs tend not be funded per referral, whereas paid representatives are – consequently any additional costs of acting as a litigation friend might be reimbursed to paid representatives but they would be unlikely to be for IMCAs.

<sup>463</sup> Public funding for Court of Protection litigation will be touched upon below, and fuller details of eligibility for public funding for legal advice and legal representation in the Court of Protection is given in Appendix C.

<sup>464</sup> Presumably because litigation friends are usually 'personally liable to the other party to the litigation for the costs of unsuccessful proceedings', *Re E. (Mental Health Patient)* [1984] 1 WLR 320.

<sup>465</sup> Rule 157 Court of Protection Rules 2007. The purpose of this 'general rule' is to ensure potential applicants are not deterred from bringing important issues to the attention of the court for fear of paying the costs of other parties, see *G v E & Ors* [2010] EWHC 3385 (Fam) [40]. However, if an IMCA initiated Judicial Review proceedings ordinary rules for costs in civil litigation would apply, and so it is possible – as the MCA code of practice notes – that IMCAs 'may be liable for the costs of the case going to court' if they initiate other types of litigation than Court of Protection welfare cases (Lord Chancellor's Office, 2007: [10.39]).

<sup>466</sup> In 2009 and 2010 the Court of Protection received 1531 and 1283 health and welfare applications respectively, but it issued only 182 and 218 orders respectively suggesting that not all cases were granted permission (Judiciary of England and Wales, 2010; 2011).



The wider question is when do disputes require IMCAs to take ‘formal’ action, including challenges to capacity assessments and best interests decisions, in the Court of Protection? The code describes merely when they *may* challenge a decision, but not when they *must* (Lord Chancellor’s Office, 2007: 10.32). One tenuous argument might run that IMCAs are ‘hybrid’ public authorities in the meaning of s6 HRA, and so may have positive obligations to challenge decisions where a human rights violation might occur otherwise. Yet this would require much greater legal clarity on whether or not IMCAs are public authorities under the HRA, and in precisely which circumstances a mental capacity assessment or best interests decision *should* be challenged. In particular, it would be important to know whether a person who disputes a best interests decision that has significant implications for them should always be assisted to ‘appeal’ against it in court. A related question would be whether responsibility for assisting them in doing so falls to the decision maker or the IMCA. As yet, these matters are remarkably unclear in law.

## 5.2.4 WHAT KIND OF SAFEGUARD ARE IMCAs?

### ARE IMCAs ADVOCATES?

Advocacy has been described as ‘fundamental to enabling people with capacity difficulties to access to justice’<sup>467</sup>. Given their title it may sound strange to query whether IMCAs are advocates, and yet there are some important differences between the way the IMCA role is constructed in law and the role of an advocate as traditionally conceived. Action for Advocacy<sup>468</sup> (2002; 2007) has produced an advocacy charter and code of practice defining key principles of good advocacy. Several of these principles seem, on the face of things, to come into conflict with the way the IMCA role is constructed by statute and regulations.

The Action for Advocacy code of practice states that ‘the wishes and interests of the people they advocate for direct advocates’ work’. By contrast, IMCAs are obliged to find out about a person’s wishes and interests and make them known, to help people participate in decision making, but nothing in statute or regulations obliges IMCAs to be *directed by* the wishes and interests of the people they ‘represent’. In particular, a person could not direct their IMCA to challenge a decision that affects them.<sup>469</sup> IMCAs interviewed for this research did say that they helped people to

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<sup>467</sup> Oral evidence of Professor Luke Clements to the Joint Committee on the Draft Mental Incapacity Bill (2003).

<sup>468</sup> A well respected NGO who provide information and guidance for advocacy services in England and Wales.

<sup>469</sup> Except in connection with the deprivation of liberty safeguards; this will be discussed in Chapter 5.

exercise their rights to challenge.<sup>470</sup> However, given the low volume of formal complaints and legal challenges it seems unlikely this is happening consistently across the service as a whole. Given that research shows that mental capacity is most often called into question where there is a conflict between what a person wants and decision makers' views of what is best for them (Emmett et al., 2012; Williams, V. et al., 2012), we would expect a very high volume of best interests decisions to be formally challenged if IMCAs always assisted people in doing so. Since the volume of challenges remains extremely low, we must assume that they are not.

The advocacy charter states that advocacy schemes should have a policy on confidentiality that states that 'information known about a person using the scheme is confidential to the scheme' and setting out 'any circumstances under which confidentiality might be breached.' Yet a significant part of the IMCA role is collecting and sharing that information with decision makers, regardless of whether or not the person they are representing wants it to be shared with them. Nothing prevents an IMCA from making known facts that are relevant to a 'best interests' decision which might guide decision makers towards outcomes which conflict with a person's wishes and interests. In an interview with two IMCAs I asked them what they did in situations where they did not regard the preferred option of the person they were representing as being in their best interests. They responded with ambivalence or discomfort at being asked this question:

'I hate this one.'

'Our opinions don't count.'

They emphasised that their role was not only making sure a person's voice gets heard and their preferences were recorded – but also to make sure other considerations were taken into account by best interests decision makers. In response to a specific question on this point, IMCAs replied that sometimes they would include in their report concerns expressed by third parties they had consulted which the person themselves did not share. They emphasised that this was not their opinion, but merely reporting evidence that they have gathered.

The advocacy charter also says that 'People who use the scheme should have a say in the level of involvement and style of advocacy support they want.' Yet there is no provision in the MCA for people to request or refuse an IMCA, or to reject a particular IMCA and request that they be supported by a different person. The MCA itself defines the type of service people will receive from an IMCA, and allows very little

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<sup>470</sup> Regrettably, however, I did not ask whether they always initiated a formal challenge if a person was unhappy with a best interests decision, nor how often this occurred.

scope for people to ‘have a say in the level of involvement’ their IMCA has in contributing towards a particular decision.

The key distinction between IMCAs and advocates as traditionally conceived is that whereas traditional advocates are instructed by their clients, IMCAs are instructed by best interests decision makers. Guidance from the Office of the Public Guardian (2007: 7) describe IMCAs as a form of ‘non instructed advocacy’ to represent a person’s ‘interests’ when ‘a person is unable to communicate their views’.<sup>471</sup> However, as just discussed, IMCAs might represent a person’s ‘interests’ even when they *are* able to express a view, and even when a person’s views come into conflict with what others perceive to be in their best interests.

‘Non-instructed advocacy’ is a relatively new and sometimes controversial form of advocacy. The term has no formal definition and relatively little has been written about it (Henderson, Rick, 2007: 2). The best known guidance on non-instructed advocacy is a document called *The Watching Brief* by Assist Advocacy (2007), which provides guidance for advocates working with people ‘who do not have a system of communication that is recognised by the advocate’. The guidance sets out values in eight domains of life<sup>472</sup> and advocates ‘ask questions relevant to those domains’ for any given proposal. Questions are re-iterated ‘until all parties are satisfied that the proposal has been thoroughly tested to identify its effect on the quality [of] life domains of the advocacy partner and, where possible, has been modified to ensure that its impact is positive’ (p4). For those who cannot communicate, the value of independent questioning and scrutiny connected with these domains may be tremendous. It certainly seems more desirable than the alternative – that the advocate just walks away from the situation because they have no ‘instructions’, and no independent party is left to ask questions relevant to a person’s rights.

However, whilst *Watching Brief* advocacy may be highly appropriate where there are communication difficulties, non-instructed advocacy centred around a person’s interests may be more problematic for people who can express a view. Although early characterisations of advocacy identify it with promoting a person’s interests (Wolfensberger, 1972), there are acknowledged tensions between ‘best interests’ advocacy and empowerment (Wolfensberger, 1972: 25). Best interests

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<sup>471</sup> However, there is no discussion of IMCAs as ‘non-instructed’ advocates in the consultation documents or the explanatory notes on the IMCA role (Department of Health, 2005c; b; 2006b). The term cropped up later on in some reports on the IMCA service by the Department of Health (2009c).

<sup>472</sup> These are: ‘competence’ (having ‘a level of skill to be able to be as independent as possible’), ‘community presence’, ‘continuity’, ‘choice and influence’, ‘individuality’, ‘status and respect’, ‘partnership and relationships’ and ‘well-being’. There are some interesting parallels between these domains and ‘capabilities’ identified by Sen, Nussbaum and others (Nussbaum, 2006; 2009; Sen, 2010).

advocacy is explicitly eschewed by some advocacy organisations, for example the Scottish Independent Advocacy Alliance (2008: 5) write that:

Sometimes people think that advocacy is about working in the best interests of an individual. In fact, sometimes the advocate is supporting an individual to do something that is not in their own best interests. Often professionals make decisions that are in the best interests of an individual because they have a legal duty to do so. Advocates do not have such a legal duty. An effective advocate needs to challenge, question and hold professionals to account when best interests are given as a reason for decisions made about their advocacy partner.

The Scottish Advocacy Alliance do, however, endorse *Watching Brief* advocacy for those who cannot *communicate* their views. A recent study on Independent Mental Health Advocates (IMHAs)<sup>473</sup> found they felt uncomfortable with non-instructed advocacy and “‘best interest’ work’, describing the central ethos of advocacy as being ‘not just person-centred but also person-driven’ (Newbigging et al., 2012: 7, 146). There is surprisingly little discussion of this issue in the research and policy literature on IMCAs.

These different approaches to advocacy go right to the heart of two conflicting constructions of personal agency that the MCA attempts to straddle. On the one hand, directed-advocacy approaches seek to supplement a person’s practical abilities to enable them to effectively ‘invigilate’ interferences with their own rights. However, non-instructed advocacy approaches are based on the presumption that a person is incapable of recognising where their rights have been violated and that a third party is better placed to defend them on their behalf. Republican writings offer no guidance as to which approach might be more desirable.

The requirements of Article 12(4) CRPD, that measures relating to the exercise of legal capacity should respect a person’s ‘rights, wishes and preferences’, would seem to favour a more directed approach to advocacy where a person is able to communicate their wishes and preferences. If IMCAs were tasked with furthering a person’s wishes and preferences, as opposed to their interests, it would be highly likely to result in more challenges and more adversarial practices, for the reasons discussed above. It is easy to see how this might lead to a dramatic increase in the volume of complaints and litigation around decisions made under the MCA, and may well mean that decision makers would be less inclined to make IMCA referrals. Indeed, the possibility of a challenge for any major decision made under the MCA with which the person themselves disagrees could pose very significant problems for the smooth running of health and social care services. Yet perhaps we should ask ourselves whether the alternative, that major care and treatment decisions that override a

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<sup>473</sup> The IMCA’s sister service of statutory advocacy under the MHA.

person's wishes and preferences, can be taken with relative ease and free from any likely prospect of challenge is desirable either?

An alternative way of thinking about IMCAs could be as a type of review mechanism. A better comparator than advocates might be Independent Reviewing Officers (IROs), appointed to monitor the wellbeing of 'looked after' children in the care system.<sup>474</sup> IROs were established because, following several inquiries into child protection, 'It was recognised that these children needed independent safeguarding from the occasional acute failings of the care system' (Griffith-Jones, 2007). Where IROs have concerns that children's human rights have been breached, they have powers to refer their case to the Children and Family Court Advisory and Support Service (CAFCASS), whose role it is to safeguard and promote the welfare of children involved in family court proceedings.

However, concerns have arisen that IROs are not as 'truly independent' from local authorities as had been hoped, and that their role is hampered by their low professional status, high workloads and a lack of access to independent legal advice (Arnold, 2011; Fortin, 2009; Griffith-Jones, 2007; House of Commons Children, 2009a; b). Like IMCAs, the number of times IROs have used their formal powers to take steps to safeguard children has been very low; by 2011 CAFCASS had received only eight referrals from IROs<sup>475</sup> and 'no application by Cafcass has been made to the court on behalf of a child as a result of a referral to Cafcass by an IRO' (Arnold, 2011: 14). It has been questioned whether IROs would 'readily identify areas of poor practice amongst their own colleagues' and their reviews have been described as 'a box-ticking exercise' (Fortin, 2009: 636-7). Recently a court found that the Article 6 and 8 rights of two boys in care, who had been moved 96 and 77 times before the age of 16, had been violated. The court found that the IRO had failed to identify that their rights had been infringed, to take effective action to ensure that the local authority acted upon the recommendations from reviews and to refer their circumstances to CAFCASS.<sup>476</sup>

The analogy between IMCAs and IROs is imperfect. Unlike IROs, IMCAs are not employed directly by the local authority – although notably IMCAs interviewed for this research found that their 'outsider' status was also problematic in performing their

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<sup>474</sup> s118 Adoption and Children Act 2002, see also Review of Children's Cases (Amendment)(England) Regulations 2004.

<sup>475</sup> By 2007 it was reported that IROs had not yet made a single referral to CAFCASS (Griffith-Jones, 2007), there were none in Wales by 2009 (Care and Social Services Inspectorate Wales, 2009). In response to an FOIA request, CAFCASS confirmed that they received 1 IRO referral in 2007, 1 in 2008, 2 in 2009, 3 in 2010 and 1 in 2011 (FOIA #17).

<sup>476</sup> *A & S (Children) v Lancashire County Council* [2012] EWHC 1689 (Fam); see also *S (A child acting by the Official Solicitor) v Rochdale Metropolitan Borough Council and the Independent Reviewing Officer* [2008] EWHC 3283 (Fam); [2009] 1 FLR 1090, as case where the Official Solicitor brought judicial review proceedings against the local authority and the IRO for inadequacies in the care of a child; the case against the IRO settled.

role. IMCAs have substantially less ongoing involvement than IROs. However, like IMCAs, IROs can have very high workloads (Arnold, 2011) and like IROs, the number of challenges brought by IMCAs has been worryingly low. There are many possible explanations for why IMCAs and IROs are reluctant to challenge, but one might be the expectation that they form their own independent view of a person's rights and welfare and have sufficient confidence in that view to initiate a challenge. There is a danger that in relying on professional judgment to bring concerns before the courts, 'those who define the goals and outcomes of service provision continue to be professionals' and not service users (Armstrong, 2002: 340). By contrast, where advocates understand their role as amplifying a person's own voice and assisting them to challenge acts that they resist, the origin of the challenge is not located within the advocate as such. Whereas 'reviewers' must feel confident in the evidence base and their understanding of the law to proceed with a challenge, an 'advocate' must merely know that their advocacy partner is unhappy with the outcome of a decision and wishes action to be taken. Instructed advocates may therefore find it easier to navigate a lack of confidence in their own opinions, and the social dilemmas of challenging decision makers, as they exercise less personal judgment in initiating challenges. It is beyond the scope of this thesis, but it would be interesting to explore empirically whether the subjective experiences of advocates and 'reviewers' reflect this hypothesis, and whether this impacts upon their readiness to challenge.

### ARE IMCAs INDEPENDENT?

Republicans emphasise the importance of enforcement mechanisms being external to those exercising power. Although IMCAs belong to legally distinct organisations to decision-makers, there are some structural factors that condition their independence with respect to decision makers. I have already touched upon the tensions for IMCAs between preserving relationships with decision makers, who are responsible for future referrals and are gatekeepers to much information IMCAs need to access for their role, and being prepared to challenge their decisions.

Further concerns arise around commissioning structures. Local authorities are responsible for funding and arranging the very IMCA services that are intended to act as an independent check and, sometimes as a brake, on their decision making. During the consultation on the IMCA service, half of respondents felt that funding for the service should be held centrally because of 'conflicts of interest if funding were allocated by the LA or PCT to which advocacy organisations were providing a service' (Department of Health, 2005b: 8). There is a danger that IMCA service providers – even if not individual IMCAs – may feel constrained in how far they can hold local authorities to account and challenge their decisions if they are dependent upon that

self-same local authority choosing to commission their service again in the future. Not all IMCAs may subjectively experience these tensions, but the very structure of commissioning and referral patterns does threaten to compromise the independence of the IMCA role. It is not desirable that the efficacy of IMCAs as a safeguard is so closely linked to the esteem they are held in by those whose actions they are supposed to be holding in check.

### ARE IMCAs AN EFFECTIVE SAFEGUARD?

IMCAs were introduced in response to widespread demands for greater safeguards on best interests decisions made under the 'general defence', but it is not clear that they can satisfy this role. IMCAs may enhance the quality of decision making under the MCA by providing better quality information for decision makers and helping – as far as is possible within the resource and other constraints of their role – to include a person in the decision making process. However, research and official data on the IMCA service suggests that IMCAs rarely assist people affected by decisions to bring challenges against decision makers, or instigate such challenges of their own accord. This suggests that IMCAs may be a very weak safeguard against mental capacity assessments and best interests decisions that depart from accepted legal standards.

In a broader sense, even if IMCAs were more effective in challenging poor decisions under the MCA, their role is limited to a very small proportion of decisions made under the MCA every day. Their role is short term and decision specific, leaving an unbefriended person with few safeguards against other decisions made under the 'general defence' that did not merit IMCA involvement, and yet which might have significant repercussions on their quality of life. Short term involvement of IMCAs does little to 'empower' a person overall as the MCA claims to do, and stands in contrast with models of support for people with mental disabilities in other jurisdictions.<sup>477</sup>

Furthermore, IMCAs are not instructed where a decision maker regards a person as suitably 'befriended' by friends or family. Yet friends and family are likely to have limited knowledge of the MCA, and are poorly placed to identify when decision

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<sup>477</sup> For example, the Swedish Personal Ombudsman scheme is often favourably cited in the literature around Article 12 CRPD (Centre for Disability Law & Policy, 2011; Dhanda, 2006-7; Morrissey, 2012). The Personal Ombudsmen system is similar to personal and peer advocacy, and provides people with mental-disabilities with long term support, at a time and place and in a manner of their choosing. For example, an ombudsman might support a person through regularly meeting to talk with them, or they might help them advocate to others or negotiate complaints and other bureaucratic processes which affect their lives. Personal ombudsmen use a very 'directed' model of advocacy, which is premised upon trust, confidentiality, flexibility and a minimum of bureaucracy. Another interesting contrast with the IMCA approach taken by the UK is a bill currently beginning its passage through the National Parliament in India. Section 9 Draft Rights of Persons with Disabilities Bill 2012 (India) establishes a 'duty to provide support in exercise of legal capacity', which includes a duty upon regional authorities to 'mobilize the community and create social networks to support persons with disabilities in the exercise of their legal capacity.'

makers have departed from the requirements of the MCA. Families are likely to be unfamiliar with mechanisms for challenging best interests decisions, and may face serious ‘access to justice’ difficulties – some of which are outlined below. Disability charities have repeatedly raised concerns that family carers of people with learning disabilities are not being consulted in accordance with the MCA in healthcare decisions, resulting in poor care and treatment decisions and even death (Ambitious about Autism et al., 2012; Mencap, 2012; Mencap and Challenging Behaviour Foundation, 2012a).

Neither are family members ‘advocates’ in the sense of reliably promoting the wishes (or even the interests) of people with disabilities themselves. Research has repeatedly found that family carers of people with learning disabilities can be resistant to promoting their rights to make choices about their own lives (Bowey, L. and McGlaughlin, 2005b; Jingree, Treana and Finlay, 2011; Heyman and Huckle, 1993; Heyman, 1995; McGlaughlin and Gorfin, 2004; Walmsley, 1996; Williams, V. and Robinson, 2001). Some researchers have expressed concern that family carers may not be able to make ‘impartial’ decisions about a person’s right to make an unwise decision (Manthorpe et al., 2009: 890). Others have emphasised that carers have ‘their own set of entitlements and interests’ which may come into conflict with people with learning disabilities and limit their independence as advocates (Keyword, 2003: 363). Empirical research has found that family carers sometimes heavily influenced clinicians in best interests decision making and could lead to the person themselves being excluded from the process (Redley et al., 2012: 6-7). Insofar as family carers and best interests decision makers are in agreement with professionals about what is in a person’s best interests, a person’s right to make an unwise decision may be poorly protected.

These considerations raise wider questions about when, and how, people who are the subject of ‘best interests’ decisions which they disagree with should be supported to challenge them. This is a rapidly evolving area of law in the European Court of Human Rights (ECtHR), but has yet to make a significant impact on domestic litigation.<sup>478</sup> All the situations calling for IMCA referrals must, surely engage Article 8. It is well established that interferences that engage Article 8 ECHR must be ‘in accordance with the law’, which must in turn be ‘accessible to the person concerned’.<sup>479</sup> Furthermore, a growing body of ECtHR case law related to Articles 6 and 8 has found that a person must be able to challenge a decision that deprives them

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<sup>478</sup> The domestic authorities will be discussed in connection with applications to the Court of Protection, below, and those connected to bringing Article 5 claims, which will be discussed in Chapter 5.

<sup>479</sup> *Herczegfalvy v Austria*, [88]; *X v Finland*, [215]. See also *J Council v GU & Ors (Rev 1)*, [11].



of their legal capacity to act in a matter which engages their Convention rights.<sup>480</sup> The majority of this case law has considered situations where a person's access to the law is barred by formal 'deprivation of legal capacity' procedures, which is not quite the case for decisions made under the MCA. The obstacles people with learning disabilities in England face in challenging such decisions are complex, and are discussed in more detail below.

The ECtHR has taken some tentative steps towards finding that states are under some positive obligations to ensure that the law is accessible to people with disabilities. In *Stanev v Bulgaria* the court held that 'special procedural safeguards may be called for in order to protect the interests of persons who, on account of their mental illness, are not fully capable of acting for themselves'.<sup>481</sup> The nature of such safeguards is not clearly spelled out, although in *RP v UK*<sup>482</sup> the ECtHR held that the appointment of a litigation friend will only be compatible with a person's Article 6 rights:

...if the fact of his appointment, the implications of his appointment, the existence of a means of challenging his appointment and the procedure for exercising it are clearly explained to the protected person in language appropriate to his or her level of understanding.<sup>483</sup>

One might infer from that that in order for a 'best interests' decision to be compatible with a person's Convention rights, the existence of a procedure for challenge such decisions must be brought to their attention. A key weakness of the ruling in *RP v UK* is its lack of attentiveness to the further practical assistance a person with learning disabilities may need in accessing such procedures in order for their rights to challenge decisions to be 'practical and effective' rather than 'theoretical and illusory'.<sup>484</sup> These are issues which the courts have yet to consider, yet they will have important implications for the role IMCAs may play in assisting a person to challenge decisions which affect them.

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<sup>480</sup> *Shtukaturov v Russia* (App no 44009/05) [2008] ECHR 223 [71], [90]; *Salontaji-Drobnjak v Serbia* (App no 36500/05) [2009] ECHR 1526, [144]; *X and Y v Croatia*, [67]; *Stanev v Bulgaria*, [170] - [177], [241]; *D.D. v Lithuania*, [118]; *X v Finland*, [220]; *RP v UK*, [72]; *Sýkora v The Czech Republic* (App no 23419/07) [2012] ECHR [102].

<sup>481</sup> [170]; see also *Sýkora v The Czech Republic* [82].

<sup>482</sup> (App no 38245/08) [2012] ECHR 1796

<sup>483</sup> *RP v UK*, [72].

<sup>484</sup> *Airey v. Ireland*, [24]

## 5.3 THE EFFICACY OF THE COURT OF PROTECTION AS A SAFEGUARD

The Court of Protection is the final arbiter of questions of capacity and best interests.<sup>485</sup> In contrast with other jurisdictions,<sup>486</sup> there is no dedicated ‘appeal’ mechanism for decisions taken regarding a person’s mental capacity under the MCA. An application to the Court of Protection for a declaration that a person has the mental capacity to make a decision<sup>487</sup> is the mechanism that most closely approximates an appeal against a decision that a person lacks mental capacity. An application may be made by the person themselves, or a third party on their behalf. Applications to the Court of Protection might also be made where disputes arise regarding what course of action is in a person’s best interests. However, not all welfare related applications are prompted by a dispute – they might be made because a person seeks to be appointed as a deputy to make decisions on a person’s behalf<sup>488</sup>, where there is doubt about the appropriate course of action<sup>489</sup>, or because they are mandated to for a limited number of serious medical treatments.<sup>490</sup>

Regardless of who applies to court, the entire foundation of the court’s powers to make decisions on behalf of a person by way of an order, or to appoint deputies to make decisions on that person’s behalf, rests on that person lacking mental capacity.<sup>491</sup> All litigation in the Court of Protection, therefore, rests upon the court either being

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<sup>485</sup> It can also make declarations as to the validity and applicability of advance decisions (ss24-6 MCA), Lasting Powers of Attorney (ss22-3 MCA) and on matters relating to the deprivation of liberty safeguards (s21A MCA)

<sup>486</sup> For example in Scotland s16 Adults with Incapacity (Scotland) Act 2000 provides that ‘A decision taken for the purposes of this Act, other than by the sheriff, as to the incapacity of an adult may be appealed by—

(a) the adult; or

(b) any person claiming an interest in the adult’s property, financial affairs or personal welfare relating to the purpose for which the decision was taken, to the sheriff or, where the decision was taken by the sheriff, to the sheriff principal and thence, with the leave of the sheriff principal, to the Court of Session’. The Sheriff court is a local court, and a Sheriff is roughly analogous to a district judge.

<sup>487</sup> Under s15 MCA

<sup>488</sup> See ss16-20 MCA

<sup>489</sup> In *London Borough of Hillingdon v Neary & Anor*, Jackson J stated ‘Where a dilemma exists, the court provides an accessible forum. Often, parties will have a clear view of what they are proposing, but if a party needs more evidence or is uncertain about the best outcome in a difficult case, it is no shame to say so. Proceedings in the Court of Protection need not be adversarial.’ [142]

<sup>490</sup> These are listed in the code of practice as: ‘decisions about the proposed withholding or withdrawal of artificial nutrition and hydration (ANH) from patients in a permanent vegetative state (PVS)’, ‘cases involving organ or bone marrow donation by a person who lacks capacity to consent’ and ‘cases involving the proposed non-therapeutic sterilisation of a person who lacks capacity to consent to this (e.g. for contraceptive purposes)’ (Lord Chancellor’s Office, 2007: [8.18]). A Court of Protection (2007b) Practice Direction essentially replicates this guidance, but adds the withdrawal of ANH from people in a ‘minimally conscious state’, presumably in response to the case *W v M* [2011] EWHC 2443 (Fam). Bartlett (2008: [2.13]) has questioned what mechanism the courts could use to enforce this requirement.

<sup>491</sup> s16(1) MCA

satisfied that a person lacks mental capacity in relation to the matter in question, or making a declaration that they have the requisite mental capacity to make the decision for themselves. From a republican perspective, constraining the arbitrariness of the court's decisions regarding a person's mental capacity is absolutely fundamental. A republican approach therefore raises a number of questions about the Court of Protection as an effective enforcement mechanism for the MCA:

1. To what extent is the Court of Protection accessible as a means for people to challenge the basis for best interests decisions which affect them?
2. If a person is unable to initiate such litigation, to what extent can they rely upon third parties to do so on their behalf?
3. To what extent are mental capacity assessments subject to effective scrutiny by the Court of Protection?
4. To what extent does the court scrutinise the basis for best interests decisions that conflict with a person's wishes and preferences, so as to minimise the extent of any interferences?

Answering these questions relies on a careful unpicking of dry, technical and often hidden details of the processes behind litigation the Court of Protection. What follows is based on what can be gleaned from the MCA and associated case law, the Court of Protection Rules 2007, practice directions, court forms and other grey literature. Many practices are not explicitly laid down in statute, rules, practice directions or judicial or statutory guidance, so this was supplemented by interviews with the OS, solicitors with experience of Court of Protection litigation and judges. A number of recent ECtHR cases have explored the procedural aspects of deprivation of legal capacity proceedings which are, in some respects, analogous to litigation in the Court of Protection. These are considered as they build upon Convention principles associated with the 'rule of law', which are closely aligned with republican approaches. They are also likely to influence the way that Court of Protection procedures evolve in the future. These issues may appear dry and technical, but they have a profound influence on the ways in which the Court of Protection may be used to 'invigilate' interferences in the lives of people with mental disabilities, and the way the MCA is shaped and interpreted as a whole.

### 5.3.1 KEY DIFFICULTIES IN USING THE COURT OF PROTECTION TO 'INVIGILATE' INTERFERENCES PREMISED UPON INCAPACITY

#### PRACTICAL OBSTACLES FOR PEOPLE WITH MENTAL DISABILITIES INITIATING PROCEEDINGS

It is well known that people with mental disabilities experience considerable difficulties accessing justice to enforce their legal rights (Bartlett et al., 2007; Cojocariu, 2011; Equality and Human Rights Commission, 2009; 2011b; Inclusion Europe, 2007; O'Conneide, 2009; Ortoleva, 2010-11). This is one reason why the CPRD contains an article dedicated to equal access to justice for people with disabilities (Article 13). There are many potential obstacles for people with learning disabilities who live in institutions using the court to enforce their rights. At the most basic level, some people with learning disabilities have profound communication impairments which may make it difficult to even alert third parties to interferences with their rights. Disabled people often have low levels of awareness of their rights, and are often discouraged from making complaints (Equality and Human Rights Commission, 2009; 2011b). There is evidence that people with mental disabilities are often disbelieved, and can experience 'diagnostic overshadowing' so that claims that their rights have been infringed are regarded as 'symptoms' of their diagnosis (Equality and Human Rights Commission, 2009; Watson, 2002).

Making complaints or initiating proceedings against those whom people are reliant upon for care and support can be particularly problematic. People may fear retribution, or may have few or no other sources of support from people who could assist them with the practicalities of challenging their caregivers. Solicitor and legal academic Luke Clements has said that:

...for every one person with mental capacity difficulties to get to court, there are probably 100,000 who have no access because the mere concept of stepping into a solicitor's office is intimidating, as it is for all of us, and the reality is that people with mental capacity difficulties never take the first step.

Clements argues that advocacy was 'utterly fundamental' in rectifying this difficulty (Joint Committee on the Draft Mental Incapacity Bill, 2003). However, as noted above, IMCAs are only available for a very limited number of decisions and very rarely help people make formal complaints or initiate legal proceedings. Other sources of independent advocacy are increasingly drying up due to austerity cuts to local authority budgets (Action for Advocacy, 2011). To make the Court of Protection a plausible mechanism for people with learning disabilities to 'invigilate' interferences with their rights, considerable efforts would have to be made to promote their awareness of their

rights, and provide long term access to independent advocacy to help in asserting them.

Even once a person with learning disabilities has made it as far as contacting a solicitor, funding the litigation may pose a problem. Technical details of eligibility for public funding for litigation in the Court of Protection are given in Appendix C, but are summarised here. The content of litigation in the Court of Protection must fall within core categories specified by the Legal Services Commission (2011b)<sup>492</sup> (LSC): a person's right to life, a person's liberty or physical safety, a person's medical treatment, a person's capacity to marry, to enter into a civil partnership or to enter into sexual relations, or a person's right to family life. The LSC comment that 'Many welfare cases concern accommodation issues which will not as such fall within the scope of the authorisation', but accommodation cases 'will be within scope where they concern P's family life' (p285). This suggests that where adults wish to challenge placement decisions under the MCA that do not concern family life, they may have difficulties securing legal aid. Proceedings in the Court of Protection are not exempt from the 'merits' requirements for public funding that they must have good prospects of success (Legal Services Commission, 2011a).<sup>493</sup> There are also eligibility requirements relating to income and capital. People in receipt of certain 'passporting' benefits would meet these criteria.<sup>494</sup> However, those who exceed the income or capital thresholds would not be eligible, and this is especially problematic where people do not have 'liquid' capital assets – for example, they may be home owners but be unwilling or unable to sell their home to fund litigation (Official Solicitor, 2011; Pitblado, 2012).<sup>495</sup>

The Court of Protection does not keep statistics on the identity of applicants; however in an interview for this research the OS stated that in his experience applications from 'P'<sup>496</sup> are rare. When I put this question to Senior Judge Lush at the

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<sup>492</sup> And now written into Schedule 1 of Legal Aid, Sentencing and Punishment of Offenders Act 2012.

<sup>493</sup> A small number of cases are exempt from 'merits' requirements, these include certain types of cases relating to family law and mental health.

<sup>494</sup> Means tested Employment and Support Allowance is one passporting benefit. 1,131,520 people, or 43.3% of all claimants of Employment and Support Allowance have 'Mental and behavioural disorders' recorded as their main condition (McInnes, 2012).

<sup>495</sup> People who lack financial capacity will have especial problems if they have assets which exceed the eligibility criteria for public funding, as even if they have financial resources for litigation they may not be able to access them without the permission of their deputy or the donee of an LPA. In such cases where those managing their financial assets were unwilling to relinquish them for this purpose, they would very likely have to contact the Office of the Public Guardian to look into their financial management arrangements, which would be time consuming and would be a rather 'sideways' way of approaching the particular matter in question. Those who have assets, lack financial capacity but have no deputy or LPA face especial problems funding litigation (Official Solicitor, 2011).

<sup>496</sup> 'P' is defined in r6 Court of Protection Rules 2007 as 'any person (other than a protected party) who lacks or, so far as consistent with the context, is alleged to lack capacity to make a decision or decisions in relation to any matter that is the subject of an application to the court and references to a person who lacks capacity are to be construed in accordance with the Act'.

Court of Protection, he confirmed this. This suggests that although people with mental disabilities are legally entitled to use the Court of Protection to challenge allegations of incapacity, best interests decisions or other MCA-related matters that affect them, in practice they very rarely do. Access to justice issues may be a key factor in explaining this. Consequently, people with mental disabilities will be heavily reliant on third parties initiating litigation to ‘invigilate’ interferences with their rights which stray from the principles of the MCA.

## BRINGING DISPUTES TO THE ATTENTION OF THE COURT OF PROTECTION

Although the courts and MCA code have made clear that a small number of medical treatment cases must go to the Court of Protection<sup>497</sup>, the situation for disputes connected with wider welfare matters is far less clear. The MCA code of practice states that ‘cases where there is a doubt or dispute about whether a particular treatment will be in a person’s best interests’ should be brought to court. Of disputes that do not involve medical treatment it says only that ‘an application to the Court of Protection may be necessary for... particularly difficult decisions [or] disagreements that cannot be resolved in any other way’ (Lord Chancellor’s Office, 2007: [8.18], [8.3]). This guidance gives rise to two questions:

1. Which parties should be in dispute for the need for formal adjudication to arise?
2. Who is responsible for bringing disputes that require adjudication to court?

Regarding the first question, I have already touched upon ECtHR case law that may mean that people with disabilities should be supported to challenge best interests decisions that engage their Article 8 rights if they dispute them.<sup>498</sup> Domestically, however, neither guidance nor case law has clearly spelled out that advocates, public authorities, providers or others should assist a person who is alleged to lack mental capacity to challenge any best interests decisions in court.<sup>499</sup> Instead, the case law on which cases must go to court has tended to revolve around disputes between families and professionals.

Munby LJ touched upon this important issue in *obiter* remarks in *A Local Authority v A (A Child) & Anor*. Having reviewed local authorities’ powers and duties under statute and common law,<sup>500</sup> he commented that:

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<sup>497</sup> See n490 above.

<sup>498</sup> See the section entitled ‘Are IMCAs an effective safeguard?’

<sup>499</sup> The situation is slightly different for disputes where Article 5 is engaged, and this will be discussed in Chapter 6.

<sup>500</sup> At [65]. These included local authorities powers and duties to provide care services, discussed in Chapter 3, responsibilities for adult protection arising from binding guidance

...none of these sources of local authority engagement with someone like C confers on the local authority any power to regulate, control, compel, restrain, confine or coerce. They are concerned with the provision of services and support.<sup>501</sup>

Munby LJ then went on to assert that ‘if a local authority seeks to control an incapacitated or vulnerable adult it must enlist the assistance of either the Court of Protection or the High Court’<sup>502</sup>. If Munby LJ is correct, then there is a point beyond which local authorities cannot rely upon ‘necessity’ or ss5-6 MCA to ‘control, compel, restrain, confine or coerce’. Yet the point beyond which s5-6 cannot be used is not defined by Munby LJ in *A Local Authority v A (A Child) & Anor*, nor in the cases he cites in support of his principle

One might try to understand this by distinguishing ss5-6 MCA, which constitutes a defence, from a legal ‘power’. Clearly the two are distinct: infancy may be a defence to murder, but the state has not granted children under the age of 10 powers to kill. Nevertheless, this brings us little closer to understanding the limits of what can lawfully be done by relying on ss5-6 MCA. The government’s terminological shift from the ‘general authority’ to the ‘general defence’ during the passage of the Bill resulted from ‘concerns that the General Authority would allow too much licence to intervene in the lives of people who may lack capacity’ and sought to ‘make its proper intention clear’ (Department for Constitutional Affairs, 2004: [5]-[6]). Yet nowhere in parliamentary debates, in the code or in policy guidance are the limits of what interventions are permissible under the MCA set out.

The Law Commission’s work, which led to the drafting of the MCA, was clearly designed to fill the void left by the retraction of the public law powers of guardians (Law Commission, 1991; 1995). Indeed, the MHA code of practice states that ‘one potential alternative’ to relying on public law powers under guardianship ‘will be to rely solely on the MCA’ (Department of Health, 2008a: [26.10], see also [26.11], [26.13]), and guardianship – unlike the MCA – does not make provision for consent to treatment. Yet if anything this suggests that there was intended to be a *broader* range of coercive acts that can be done to a person under the MCA than under guardianship. In *Re F (adult patient)* and Munby LJ’s own ruling in *Re S (Adult Patient) (Inherent Jurisdiction: Family Life)* major decisions regarding where a person should live and restrictions on contact with family members were made through best interests declarations by the courts. In neither case was it explicitly stated that it was necessary to apply to court for such a declaration in order to invoke the doctrine of necessity for such matters.

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(Department of Health and Home Office, 2000) and common law duties to investigate ‘investigate the circumstances of a vulnerable adult whose welfare is seriously threatened by the act of another’ arising from *Re Z (Local Authority: Duty)*.

<sup>501</sup> [66]

<sup>502</sup> [68]

Further support for the suggestion that the government did anticipate that 'necessity' and the MCA could be used to 'regulate, control, compel, restrain, confine or coerce' without recourse to the courts comes from its own guidance. In binding<sup>503</sup> guidance on safeguarding, *No Secrets*, the Department of Health (2000: [6.21]) stated that 'The vulnerable adult's capacity is the key to action since if someone has 'capacity' and declines assistance this limits the help that he or she may be given'. *No Secrets* makes no reference to 'enlisting the authority of the court'<sup>504</sup> at any point. Neither does the Department of Health's (2003a; 2010c) binding guidance on community care assessment and provision of care services specify that an application to the Court of Protection is necessary if a person is to be compelled to accept particular care services in the face of opposition from themselves or their family.

Consequently, local authorities may have experienced surprise when, in Jackson J's ruling in *London Borough of Hillingdon v Neary & Anor*<sup>505</sup> he found that Hillingdon Council had acted unlawfully in not bringing the dispute between themselves and the Neary family to the Court of Protection. The basis for this aspect of Jackson J's ruling was Munby LJ's *obiter* remarks in *A Local Authority v A (A Child) & Anor*:

The ordinary powers of a local authority are limited to investigating, providing support services, and where appropriate referring the matter to the court. If a local authority seeks to regulate, control, compel, restrain, confine or coerce it must, except in an emergency, point to specific statutory authority for what it is doing or else obtain the appropriate sanction of the court: again see *Re A and C* (above) and the authorities referred to therein.<sup>506</sup>

Perhaps even more surprisingly, since this was the first time the High Court had explicitly issued a judgment based upon this principle, Jackson J found that its origins lay in Magna Carta:

"No freeman shall be taken or imprisoned, or disseised of his freehold, or liberties, or free customs, or outlawed, or exiled, or any otherwise destroyed; nor will we not pass upon him, nor condemn him, but by lawful judgment of his peers, or by the law of the land."<sup>507</sup>

From this, Jackson J held that 'Significant welfare issues that cannot be resolved by discussion should be placed before the Court of Protection, where decisions can be taken as a matter of urgency where necessary'.<sup>508</sup>

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<sup>503</sup> Issued under s7 Local Authority Social Services Act 1970

<sup>504</sup> As per Munby LJ in *A Local Authority v A (A child) and C*.

<sup>505</sup> *Neary* is an important case concerning the deprivation of liberty safeguards which will be discussed in more detail in Chapter 6

<sup>506</sup> [22]

<sup>507</sup> *Neary* [23], citing Chapter 23 of Magna Carta 1297.

<sup>508</sup> [33], see also the case of *Cardiff Council v Peggy Ross* [2011] (COP, 28 October 2011, Case No 12063905, Unreported).



Jackson J need not have looked as far back as Magna Carta to find such a principle. A growing body of ECtHR case law has found that in certain circumstances Article 8 requires procedural safeguards to ensure that interferences are 'fair and such as to afford due respect to the interests safeguarded to the individual by Article 8'.<sup>509</sup> In *Glass v UK*, where medical authorities overrode a mother's objections to administering morphine to her disabled son, the court found that 'the decision of the authorities to override [her] objection to the proposed treatment in the absence of authorisation by a court resulted in a breach of Article 8 of the Convention.'<sup>510</sup> Furthermore, 'the onus was on the Trust to take the initiative and to defuse the situation'<sup>511</sup>, and it was not sufficient to wait for the mother to apply to court in those circumstances. *Glass* suggests that in some circumstances, where agreement over a serious treatment decision cannot be secured, failure to apply to court by the body proposing the measure may result in a breach of Article 8.<sup>512</sup>

A key difficulty with applying the ruling in *Glass* to the Court of Protection is that in *Glass* the mother had clear parental authority over her son as he was a child. Relatives of people in the Court of Protection<sup>513</sup> have no such parental or other familial 'authority'. A peculiarity of the ruling in *Neary* is that the requirement to bring a welfare matter to court appears to rest upon a dispute breaking out between professionals and a person's family, not with the person themselves:

...it is undoubtedly lawful for actions to be taken by families and local authorities, acting together on the basis of a careful assessment of the best interests of incapacitated persons. The vast majority of arrangements are made in this way and involve no breach of the rights of the persons concerned.<sup>514</sup>

This perpetuates a rather unhelpful sense that so long as families and local authorities are in agreement about a person's mental capacity and best interests, there is no need for court adjudication of a person's own dispute. This must, as I have argued earlier, be incorrect: a person must have a right to challenge a major interference with their

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<sup>509</sup> *Buckley v The United Kingdom*, [76].

<sup>510</sup> [83]

<sup>511</sup> [79]

<sup>512</sup> See also *Buckley v UK*, in which the ECtHR commented that although Article 8 contains no explicit procedural requirements, 'Whenever discretion capable of interfering with the enjoyment of a Convention right... is conferred on national authorities', the decision making process 'must be fair and such as to afford due respect to the interests safeguarded to the individual by Article 8' [76]. This does not necessarily require an application to court, but it does require some kind of procedural safeguard to be put in place. In the absence of other possible safeguards under the MCA, a court application may be the only available option.

<sup>513</sup> Except in those rare cases where the Court of Protection is used for people aged between 16-18.

<sup>514</sup> [21]

Convention rights regardless of whether or not they have family and their family agree with it.<sup>515</sup>

From a republican perspective, therefore, we can see that there is considerable uncertainty over what types of disputes require the adjudication of the Court of Protection. Court of Protection judges have recently ‘discovered’ that local authorities cannot, as previously seemed to be the case, rely upon the MCA or ‘necessity’ to ‘regulate, control, compel, restrain, confine or coerce’ outside of emergencies. Given the importance of being able to ‘invigilate’ major interferences with their choices and freedoms in order to protect against arbitrariness, these tentative steps – however questionable their legal foundations – seem desirable.

Yet there are practical difficulties with the courts attempting to reign in such coercive practices through the creation (‘discovery’) of such principles in the common law. Public authorities and indeed care providers are unlikely to scour all 27,000 words of *A Local Authority v A (A Child) & Anor* for *obiter* remarks. They are much more likely to be acquainted with guidance such as *No Secrets* which gives no indication that the authority of the Court of Protection is required in the context of disputes. The principle in *Neary*, being both well publicised and part of the *ratio*, is likely to be better known, but may be more closely associated with cases involving deprivation of liberty. Furthermore, as can be seen by the impact assessment predicting that the Court of Protection would only hear 200 health and welfare cases each year (Department for Constitutional Affairs, 2005: [43]), the court was never set up to adjudicate a high volume of these disputes.

It seems probable that local authorities are not heeding Munby LJ’s dictum. In 2011-12 there were over 23,000 ‘safeguarding’ allegations involving a person’s partner or a family member (NHS Information Centre for Health and Social Care, 2012a: Table 6a). It seems likely that steps would be taken to protect the best interests of the alleged victim in a significant proportion of these cases that would be likely to result in disputes between their relatives and professionals. Yet data from the Court of Protection shows that it receives somewhere around 1,000 applications every year for welfare issues, the majority of which are refused permission (Judiciary of England and Wales, 2010; 2011).<sup>516</sup> An analysis of applications for permission to bring welfare proceedings showed that the vast majority come from the sons and daughters of P, around 14% come from P’s parents and around 7% are made by a public authority.

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<sup>515</sup> This would also appear to be supported by the ECtHR’s recent rulings in *Stanev v Bulgaria* and *Kędzior v Poland* where the court found that a person had a right to challenge decisions about their placement in social care institutions, regardless of the fact their families were either apathetic (as in *Stanev*) or had actively arranged it (as in *Kędzior*).

<sup>516</sup> For a more detailed breakdown of these data, see Table 9, Appendix C. The majority of these are likely to be ‘hybrid’ applications for welfare and property and affairs deputyships, rather than solely relating to welfare issues.

Applications from the parents of P or public authorities are markedly more likely to be granted permission than applications from other people (Series, 2012a).<sup>517</sup> Overall, however, the number of MCA welfare disputes that result in litigation is remarkably low. From a republican perspective this is unfortunate, as it suggests that where a person experiences an interference with their choices and freedoms which they, or their family, resist, the likelihood that the Court of Protection will ‘invigilate’ it is low.

#### THE ROLE OF LITIGATION FRIENDS IN CONTESTING CAPACITY ASSESSMENTS AND BEST INTERESTS DECISIONS

The instigation of litigation in the Court of Protection is no guarantee that the basis for an intervention under the MCA will be thoroughly adversarially tested, even if P objects to it. Once proceedings in the Court of Protection are initiated, the Court of Protection Rules 2007 provide that P may be bound as if a party to proceedings without actually being joined as a party in his own right.<sup>518</sup> If ‘P’ is joined as a party to proceedings he will be represented through a litigation friend in the vast majority of cases. The main function of a litigation friend is to ‘carry on the litigation on behalf of the plaintiff and in his best interests’, and he is ‘responsible to the court for the propriety and the progress of the proceedings’.<sup>519</sup> A second rationale for the use of litigation friends is that ‘A defendant is entitled to expect that he will not be required to defend proceedings brought against him by a person of unsound mind acting without a next friend.’<sup>520</sup> A litigation friend must be able to conduct proceedings ‘fairly and competently’ and have ‘no interests adverse to those of that person’.<sup>521</sup> In civil proceedings very often a family member will act as litigation friend. However in the Court of Protection, where typically there may be disputes about a person’s best interests that involve their family, relatives may not be regarded as sufficiently impartial to act as litigation friend.<sup>522</sup> In such cases, the OS<sup>523</sup> must be appointed as a litigation

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<sup>517</sup> Charts describing these data are reproduced in Appendix C, see Figure 10, Figure 11, Figure 12 and Figure 13.

<sup>518</sup> r74 Court of Protection Rules 2007. According to the consultation on the Rules, this reflected earlier practices in the ‘old’ Court of Protection, which dealt with property and affairs, whereby a person was only sometimes joined and represented as a party to proceedings in their own right. By contrast, they would always be named as a defendant in the High Court for health and welfare proceedings (Department for Constitutional Affairs, 2006). Responses to the Rules consultation were mixed, with some preferring that a person’s interests be represented only where the court feels it is appropriate; others argued that the person ‘at the heart of the case’ be represented through a litigation friend for all but the most straightforward financial deputyship applications (Department for Constitutional Affairs, 2007: 16-17). The Rules do not provide guidance on when P must be joined as a party, and there is no data to reveal the court’s current practices.

<sup>519</sup> *Re E (Mental Health Patient)*

<sup>520</sup> *Masterman-Lister v Brutton & Co* [2002] EWCA Civ 1889 [65]

<sup>521</sup> Court of Protection Rules 2007 rule 140, see Civil Procedure Rules rule 21.4 for the analogous provision in other civil proceedings.

<sup>522</sup> For example, in the case *G v E* [2010] EWHC 2512 (COP) the sister of a man who had been unlawfully deprived of his liberty applied to replace the Official Solicitor as his litigation friend.

friend of last resort. Consequently, the OS represents 'P' in the vast majority of cases in the Court of Protection where P is joined as a party.

Because litigation friends must conduct proceedings in the 'best interests' of P, the possibility arises that they will conduct litigation in a way that conflicts with P's expressed wishes and preferences. A litigation friend may decide, for example, not to contest a finding that P lacks mental capacity or may advance best interests arguments that conflict with what P wants. Some reported cases give very striking examples of this phenomenon. In *Re E (Medical treatment: Anorexia) (Rev 1)* the OS argued that a young woman with anorexia lacked the mental capacity to refuse re-feeding treatment, that it was in her best interests to be force fed against her will, and that two advance decisions she had prepared prohibiting such treatment were invalid. In this case, as barrister Barbara Hewson (2012) remarked, 'the only people arguing for Ms E to be left alone were her parents, who did not have legal representation.' However, it should also be observed that in some cases the OS *does* argue that what a person wants is also in their best interests.<sup>524</sup> In a small number of cases the OS has also argued that a person has capacity to make a particular decision – even an unwise decision.<sup>525</sup> These cases seem, however, to be very rare.<sup>526</sup> And in some cases the wishes and preferences of P cannot be discerned at all.<sup>527</sup>

This means that in some circumstances, the acts of a litigation friend may become a source of 'interferences' with a person's choices and freedoms in themselves. This section will present a republican critique of the role of litigation friends in the Court of Protection on the following grounds:

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Baker J found that 'there is cause to question whether G has the necessary objectivity to act as litigation friend on behalf of her brother. It is not uncommon for family members to have strong feelings about the misfortunes that befall their relatives. Indeed, it is entirely understandable. But there is a danger, in some cases, that such feelings may cloud judgment.' [73]

<sup>523</sup> The OS is an office holder, presently located within the Ministry of Justice, who has a staff of case managers whom he directs which manage cases on his behalf. The role of the OS is not described anywhere in statute, and is poorly documented in textbooks and written materials. Information about the role of the OS was gathered in interviews with the OS and solicitors, as well as various presentations and reports written by his office (Office of Court Funds Official Solicitor and Public Trustee, 2008; 2009; 2010; Office of the Official Solicitor and the Public Trustee, 2011; Pitblado, 2012).

<sup>524</sup> For example, in *LB Haringey v FG & Ors* (No.2) [ 2011] EWHC 3933 (COP) the OS argued that a young woman should not be made to live with her mother against her wishes, notwithstanding that her mother wanted her to. The court agreed. In *NHS Trust v K & Ors* the OS argued that a woman should not have a surgery which she refused, but this was less by reference to her wishes than by reference to the risks of the surgery itself. The court disagreed and found that surgery was in her best interests. See also *London Borough of Hillingdon v Neary & Anor*.

<sup>525</sup> In *Local Authority X v MM and KM* the OS argued that a woman had the capacity to consent to sex, notwithstanding that she lacked the capacity to consent to contact with her sexual partner. See Chapter 4 for further discussion of this case.

<sup>526</sup> In interview for this research I asked the OS whether there were examples of where a person might have capacity to make a particular decision, but lacks litigation capacity, where the OS has supported him to assert his right to make an unwise or eccentric decision. He replied that the situation was 'technically possible' and cited *Local Authority X v MM and KM* as an example.

<sup>527</sup> This is especially true of cases about people with disorders of consciousness, e.g. *W v M*.

1. The evidence that P lacks mental capacity to make a particular decision may be accepted by all parties to the case, and hence will not be fully adversarially tested, even if P himself disputes this. This potentially deprives P of his right to appeal against mental capacity assessments which he disputes.
2. Litigation friends make 'best interests' decisions which have significant repercussions for how litigation is pursued on behalf of a person, yet there are inadequate structural safeguards to ensure that these decisions are not arbitrary.

This critique centres on the role of litigation friends in the Court of Protection, and is not intended to be a critique of their role in other kinds of litigation, which raises different issues.<sup>528</sup> As noted in Chapters 1 and 2, domination is a structural phenomenon, and the critique that follows is not directed towards the current incumbent of the role of the OS, whose work I hold in high esteem.<sup>529</sup>

#### EVIDENCE OF INCAPACITY

The OS confirmed in an interview for this research, and has stated elsewhere (Pitblado, 2012), that he bases decisions on whether to bring or continue proceedings and what case to advance on the evidence of experts. This is an entirely understandable approach given that the OS and his case workers do not profess any kind of personal expertise in the assessment of mental capacity or determining best interests, and they have only limited contact with those they represent.<sup>530</sup> This means, however, that any cases run by litigation friends taking this approach would be unlikely to contest in court any expert evidence they receive. There have been a small number of cases where the OS has done so, but this has tended to be due to an expert's lack of familiarity with the MCA and the Court of Protection rather than because the OS

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<sup>528</sup> In particular, there is a danger that a person may be awarded significant costs for litigation which they lose, or the danger that a person who does not fully understand their claim may settle prematurely for an inadequate amount of compensation, see: *Dunhill v Burgin* [2011] EWHC 464 (QB), *Dunhill v Burgin* [2012] EWCA Civ 397 and *Dunhill v Burgin* [2012] EWHC 3163 (QB).

<sup>529</sup> In particular, his tenacity in pursuing such cases as *J Council v GU & Ors (Rev 1)*, *P & Q v Surrey County Council* and *Cheshire West and Chester Council v P*, to achieve better protection for the human rights of care service users. Likewise, he has been a careful and formidable critic of the reforms to legal aid which will have serious repercussions for the people whom he is invited to represent (Official Solicitor, 2011).

<sup>530</sup> In interview the OS stated that most contact with clients was mediated through their solicitors. In a recent presentation he gave, he explained that 'given my existing resources and the number of cases I have to work with at any one time, it is simply impracticable (save in exceptional circumstances) for my case workers to attend for personal meetings, although there may be direct telephone or written contact between P and the case worker... It may be impractical for them to attend court, even for the final hearing.' Mr Pitblado, the current incumbent of the role of OS, observed that this was 'imperfect' but 'what we have to work with' (Pitblado, 2012).

himself has arrived at a different conclusion as to a person's mental capacity.<sup>531</sup> The likelihood of others challenging the evidence that P lacks mental capacity is also slim, given that for the most part the conflict will be over which view as to P's best interests will prevail.

Lewis (2012a) has critiqued practices in guardianship jurisdictions where evidence regarding a person's mental capacity is not adversarially tested, and counter-evidence is not presented. This also appears to be a danger in the Court of Protection, where the evidence of a person's mental capacity may not be fully adversarially tested if the OS and other parties are in agreement that P lacks mental capacity. Very often, of course, the court will still consider questions of mental capacity where there is an important legal question about which test should be used.<sup>532</sup> Yet this is not the same as the court hearing adversarial arguments and evidence on behalf of a person who seeks to assert their mental capacity. *CC v KK* is a striking example of a case where a judge found that all the expert evidence before the court on incapacity was incorrect, and that KK had mental capacity. There does seem to be a danger that such opportunities for a judge to scrutinise and reject expert evidence of incapacity, even all the expert evidence, will be lost if the very argument that is put forward by a litigation friend is based upon that evidence.

#### LITIGATION FRIENDS' DECISIONS ABOUT WHETHER, AND HOW, P'S CASE SHOULD BE ADVANCED

The question of what case should be advanced by a litigation friend was recently tested in *RP v UK*. The case originated in the Family Division of the High Court.<sup>533</sup> A young woman with learning disabilities alleged that the OS's decision to concede, on her behalf, proceedings under the Children Act 1989 for the removal of her son from her care breached her rights under Articles 6 and 8 ECHR. In a lengthy statement given as an appendix to the Court of Appeal's judgment the OS explained that:

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<sup>531</sup> For example, in *CYC v PC and NC* the OS and another party challenged the evidence of an expert that PC lacked the capacity to decide whether to resume her marriage with a convicted sex offender who had been released from prison. The OS's reasons are not given, but could be inferred from the judgment as being the same as the reasons Hedley J rejected his evidence: because the expert assessor came close to appearing to conflate incapacity with making an unwise decision, and 'betrayed a lack of familiarity with the wider workings of the Mental Capacity Act in the Court of Protection' [12]. In *SC v BS* the OS raised concerns about an expert report on capacity as the expert had communicated his preliminary view that BS had capacity to her, and there were concerns about the expert's lack of expertise with the MCA (Baker J commented 'it could not be satisfactory to seek the expert opinion from someone who perceives the need to undergo training before he can give that opinion').

<sup>532</sup> This has been the case for many cases around the capacity to consent to sex and/or contact.

<sup>533</sup> *RP v Nottingham City Council & Anor* [2008] EWCA Civ 462

...in the absence of any special features calling for distinctive treatment, the correct course for the Official Solicitor to take is to present any realistic arguments and relevant evidence that may be available on behalf of (i.e. in support of) the parent in relation to the issues before the court, whether these are issues of threshold, welfare or consent. The criterion should be whether the point is reasonably arguable, not whether it is likely to succeed.<sup>534</sup>

In interview the OS confirmed that the same approach was taken in Court of Protection proceedings. He confirmed that he and his case workers would not run 'unarguable' cases<sup>535</sup>, including appeals against detention under s21A MCA. When RP took her case to Strasbourg, the ECtHR affirmed that 'it was not only appropriate but also necessary'<sup>536</sup> in connection with RP's Article 6 right for her interests to be represented in the proceedings. The court then stated 'it would not have been in R.P.'s - or in any party's - best interests for the OS to have delayed proceedings by advancing an unarguable case' although 'it was imperative that her views regarding K.P.'s future be made known to the domestic court.'<sup>537</sup>

As the Court of Appeal noted in *Buxton v Mills-Owens*<sup>538</sup>, 'it may be difficult to draw the line between an argument which can properly be articulated and put forward (but which has little, if any, prospect of success) and an argument which cannot properly be articulated and which is believed to be bound to fail.'<sup>539</sup> The difference between an argument that cannot be articulated, and an argument where the evidence itself is weak or non-existent, may be especially difficult to discern. Setting aside the circumstances in RP, which are proceedings of an entirely different sort from those under discussion here, I suggest that it can never be *unarguable* that a person who is able to communicate a wish or preference lacks mental capacity. Given that there is a statutory<sup>540</sup> and common law<sup>541</sup> presumption of mental capacity which must be rebutted by those arguing that a person lacks mental capacity, surely it is always *arguable* that a person has capacity until those claiming incapacity have demonstrated otherwise to the court?<sup>542</sup> For tactical reasons it might sometimes be more effective to challenge an

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<sup>534</sup> Paragraph 8 of Annex B of the judgment in *RP v Nottingham City Council & Anor*

<sup>535</sup> To quote him directly: 'If we think there's no chance of it being run, no arguable case, then we don't run it.'

<sup>536</sup> [67]

<sup>537</sup> [76]

<sup>538</sup> [2010] EWCA Civ 122

<sup>539</sup> [43]

<sup>540</sup> s1(2) MCA

<sup>541</sup> See, e.g., *CC v KK* [18], [74]-[75]; *E v Channel Four Television Corp* [2005] EWHC 1144 (Fam); [2005] EMLR 30 [61], [103]

<sup>542</sup> A similar approach is taken in appeals under the MHA, where it is for the hospital to prove that the grounds for detention pertain, not the patient to prove that he is not from a mental disorder that warranted detention. The initial drafting of s72-3 MHA had required patients to prove they were no longer detainable; the Court of Appeal found that this was incompatible with their rights under Article 5 ECHR in *R (H) v MHR North and East London Region* [2001] EWCA

interference by arguing that it is in a person's best interests to make a decision which accords with their wishes and preferences. In such cases, again, it is hard to see how it would be unarguable to give effect to their wishes and preferences, since they are a key consideration under s4 MCA, and are likely to be the least restrictive alternative in accordance with s1(6) MCA. The Law Society (2011) advises solicitors representing clients appealing against detention under the MHA as follows:

You can, and must, refuse to advance an argument which is not 'properly arguable', despite instructions to do so, consistent with the duty in the Solicitors' Code 2007<sup>543</sup>, para 11.01(3): see *Buxton v Mills-Owens*... However a submission may be 'properly arguable' even if it has few, if any, prospects of success... It will depend upon the context and your judgment. Given the 'least restrictive alternative' principle in s 1(6) of the Mental Capacity Act 2005 it would be in a rare case that to seek a client's discharge in accordance with his or her express wishes would not be 'properly arguable', although it will be a matter for your judgment in each case.

Similar considerations for arguability, I suggest, would apply in the Court of Protection.

The role of litigation friends in the Court of Protection poses something of a conundrum. On the one hand the ECtHR has affirmed in several cases concerning deprivation of legal capacity that Article 6 secures a 'right to a court' to 'anyone who considers on arguable grounds that an interference with the exercise of his (civil) rights is unlawful and complains that he has not had the possibility of submitting that claim to a tribunal meeting the requirements of Article 6'.<sup>544</sup> In *Stanev* the ECtHR held that 'the right to ask a court to review a declaration of incapacity is one of the most important rights for the person concerned' as it would impact upon his other Convention rights.<sup>545</sup> On the other hand, in *RP v UK*, the ECtHR has committed itself to the view that Article 6 requires that a person's interests – as opposed to what they want – must be represented in court. The difficulty lies in what happens to a person's right to have their arguable case heard before a court where a litigation friend does not regard it as being in their best interests for the case to proceed, or where the litigation friend does not seek a court review of a finding that they lack mental capacity.

It seems as if one way in which litigation friends may circumvent this dilemma is by conflating what they regard as in their client's best interests with what is 'properly arguable'. Yet, as discussed above, there must be circumstances in which the case

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Civ 415, and the MHA was subsequently amended such that hospitals must satisfy tribunals of the grounds for detention, not patients the grounds for discharge.

<sup>543</sup> This has now been replaced with the Solicitors Regulation Authority Handbook (Solicitors Regulation Authority, 2011).

<sup>544</sup> *Ashingdane v United Kingdom* [1985] 7 EHRR 528 [55], see also: *Salontaji-Drobnjak v Serbia*, [132]; *Stanev v Bulgaria*, [229]; *Kędzior v Poland*, [83].

<sup>545</sup> [241]



which appears to a litigation friend to be in a person's best interests conflicts with their 'properly arguable' claim that they have the mental capacity to make a different decision. But litigation friends cannot simultaneously advance both cases on their behalf; the case of *Re E (Medical treatment: Anorexia) (Rev 1)* is an example of one such case.

A related difficulty is the ECtHR's assertion that:

Remedies the use of which depends on the discretionary powers of public officials and which are, as a consequence, not directly accessible to the applicant cannot be considered as effective remedies within the meaning of Article 35 § 1 of the Convention<sup>546</sup>

It is difficult to reconcile the ECtHR's decision in *RP v UK* to the reality that litigation friends – including the OS – exercise considerable discretion over a person's access to an effective remedy to challenge best interests decisions.

### SOLUTIONS TO THE DILEMMA

There are several possible solutions to both the republican and the Article 6 dilemma, yet few are entirely satisfactory. The first is that adopted by the ECtHR itself in *RP v UK*, to suggest that people are safeguarded against arbitrary decisions by litigation friends through the existence of a mechanism to challenge their appointment.<sup>547</sup> Another approach, also endorsed by the ECtHR in *RP v UK*,<sup>548</sup> is to require litigation friends to always present a person's own views to the court, even if they are not arguing for them. A third approach would be to enable a person themselves to put their case directly to the court, even if their litigation friend advanced a different case. A fourth approach – the most radical but, I suggest, the most compatible with both the commitments of Article 6 and republican concerns – would be for litigation friends in the Court of Protection to advance the strongest possible case they can put together for what a person actually wants.

The ECtHR held that:

...in order to safeguard R.P.'s rights under Article 6 § 1 of the Convention, it was imperative that a means existed whereby it was possible for her to challenge the Official Solicitor's appointment or the continuing need for his services.<sup>549</sup>

The court found that RP could have used the OS's complaints procedure or applied to court herself for such a purpose, yet these suggestions are neither especially independent nor especially accessible when one examines them closely.

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<sup>546</sup> *X and Y v Croatia*, [64]; see also *Stanev v Bulgaria*, [247].

<sup>547</sup> *RP v UK*, [70]

<sup>548</sup> [76]

<sup>549</sup> [70]

An application to the court to terminate the appointment of a litigation friend would require considerable knowledge of court processes and procedures and assistance navigating them.<sup>550</sup> It seems unlikely in the extreme that an ordinary litigant would possess the requisite knowledge and abilities to do so without the assistance of legal advisors, let alone a person with borderline mental capacity to conduct litigation. It should be recalled that RP herself was only able to do so with the dubious ‘help’ of an MP; assistance which resulted in an extraordinary and notorious exchange between the MP and the presiding judge which deflected attention from the important Article 6 issues at stake and did little to advance RP’s case.<sup>551</sup> In order to be able to make use of this right to challenge the appointment of a litigation friend, a person must have access to the appropriate help they will need to do so – otherwise they will be driven to seek assistance from questionable sources. Yet people who have been found to lack the mental capacity to litigate will experience difficulties obtaining such help, as a solicitor who takes instruction from them may be negligent<sup>552</sup> or in breach of their professional code (Solicitors Regulation Authority, 2011: 18). I asked two of the solicitors interviewed for this research what they would do if a client whom they were representing, who had a litigation friend, asserted that they had the capacity to litigate. They confirmed that they would not take instruction from this client to make an application to the Court of Protection to consider their litigation capacity, but would refer this matter to the OS.

Even if a person were able to locate a solicitor who felt able to take their instructions, they would require payment, as might any experts they instructed for the requisite evidence on their mental capacity. Yet there are no obvious sources of public funding for contesting the appointment of litigation friends. Furthermore, a person who is said to lack financial capacity might not have access to their own personal financial resources for such a purpose.

Where the OS becomes aware that a client of his is asserting that he has capacity to litigate, he confirmed in interview that the case manager would have to make a decision about whether or not to apply to court for the matter to be determined by a judge. This, he said, would depend upon how credible the person’s claim was. Where a client made such a claim via the OS’s complaints mechanism, presumably the

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<sup>550</sup> In the Court of Protection, one would have to know that the relevant provision for the termination of the appointment of a litigation friend is found under either r147 or r148 Court of Protection Rules 2007. According to a practice direction issued by the Court of Protection (2007a: [20]) ‘the application must be supported by evidence that P or the protected party now has capacity to conduct the proceedings in question.’ The person would need to complete the requisite form to submit to the Court of Protection (a COP9 – as this would be an application within proceedings).

<sup>551</sup> See paragraphs [80]-[99] of *RP v Nottingham City Council & Anor*.

<sup>552</sup> *Masterman-Lister v Brutton & Co*, see also *Dunhill v Burgin* [2012] EWCA Civ 397; (2012) MHLO 33.

case managers would have to make a similar decision. Without wishing to cast doubt in any way on the integrity, experience and care which the OS and his case manager bring to such decisions, this arrangement does seem – as the EHRC put it in their submissions in *RP v UK* – ‘institutionally unsatisfactory’.<sup>553</sup> This procedure would not satisfy the republican requirement that checks against arbitrary decisions be external to the decision maker – nor the analogous maxim of natural justice that *nemo iudex in causa sua*<sup>554</sup>.

The second safeguard endorsed in *RP v UK* was for a litigation friend to represent a person’s own views in court without actually endorsing or arguing for them. Yet this hardly seems likely to produce a fair and thorough adversarial testing of the basis for any interferences that P resists. Solicitors and barristers (I am sure they would agree) serve an important purpose in presenting to the court the best possible argument for their client’s case. They have a knowledge of law which is not usually matched by their clients, and they are aware of what evidence and reasoning may persuade a judge. If advocates and counsel merely relayed to the court what their client had told them, there would be little point in their existence. In *CC v KK*, for example, KK’s counsel argued forcefully and persuasively that KK had capacity and that experts had erred on the basis of a very sophisticated understanding of what a good mental capacity assessment should look like. It is extremely unlikely that such a case would be put by counsel who are also arguing, on the basis of that self-same evidence, that a person lacks mental capacity.

The third possibility was that a person could be enabled to participate directly in proceedings themselves in order to ensure their views are made known to the court, and/or to persuade the court of their mental capacity. This could occur either by a person attending court in person, or perhaps also via a visit to that person by the presiding judge. Court rules provide that the court may ‘hear P on the question of whether or not an order should be made’<sup>555</sup>, but do not require it to. A court may also exclude a person from proceedings which they are the subject of,<sup>556</sup> but there is little guidance specifying when this is permissible and when a person must be enabled to

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<sup>553</sup> The EHRC have kindly permitted me to reproduce these submissions on my blog: <http://thesmallplaces.blogspot.co.uk/2011/05/strategic-litigation-by-ehrc.html> [accessed 11 January 2013]

<sup>554</sup> ‘No man should be a judge in their own cause.’

<sup>555</sup> Court of Protection Rules 2007 rule 88(1). This applies even if P is not a party to proceedings, as in some cases – as used to happen in the ‘old’ Court of Protection before the MCA – P might be ‘bound as if a party’ by a decision without ever being joined and represented in his own right. This is made possible under rule 74 Court of Protection Rules; see the consultation on the Court of Protection Rules 2007 for the basis for the decision to continue the practice (Department for Constitutional Affairs, 2006; 2007).

<sup>556</sup> Court of Protection Rules 2007 rule 88(2): ‘The court may proceed with a hearing in the absence of P if it considers that it would be appropriate to do so’.

participate. In *LB Hammersmith and Fulham v MW*<sup>557</sup> HH Judge Horowitz QC acceded to the request of the OS and the local authority that MW should not be permitted to attend court on the basis that 'it would be pressure to him and not conducive to the maintenance of his good mental health'.<sup>558</sup> Disappointingly, HH Judge Horowitz QC gave no discussion of the Article 6 issues raised by this decision and there was, therefore, no discussion of whether the decision to prevent MW from attending a case that was about him was necessary and proportionate. Nor did the judge report making any efforts to meet with MW in person outside of proceedings.

A small number of judgments do describe P attending proceedings,<sup>559</sup> others describe judges making efforts to meet with P<sup>560</sup>, including in one case where P was in a minimally conscious state.<sup>561</sup> In *Re J*<sup>562</sup> HH Judge Marshall QC found a visit to Mrs J 'extremely illuminating, as many pieces of the jigsaw then fell into place'.<sup>563</sup> In *CC v KK Baker J* described it as 'unusual' although not 'unique' for the subject of proceedings in the Court of Protection to give oral evidence,<sup>564</sup> yet *CC v KK* is testament to the transformative effect their participation can have. Participation in proceedings does, however, need to be approached with some care. Even amongst those who wish to participate may experience stress and anxiety at the prospect<sup>565</sup> and there have been cases where participation has not been managed well, such that P has had distressing experiences in the courtroom.<sup>566</sup> Creative thinking around special measures to assist with participation, and judicial sensitivity, will be paramount.

Recent ECtHR cases may mean that Court of Protection judges must make greater efforts to ensure they meet the people whose lives their judgments concern. In *Shtukurov v Russia* the court held that Mr Shtukurov's participation in proceedings concerning his legal capacity was 'necessary not only to enable him to present his own case, but also to allow the judge to form his personal opinion about the applicant's mental capacity'.<sup>567</sup> Consequently, in circumstances where 'he had been a relatively

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<sup>557</sup> *Re MW*, discussed in Chapter 4 under 'Institutional control over relationships with family and friends'.

<sup>558</sup> [29]

<sup>559</sup> e.g. *Re MP, LBH v GP*.

<sup>560</sup> E.g. *LB Haringey v FG & Ors (No.2)*; *Re J* [2011] CoPLR Con Vol 717

<sup>561</sup> *W v M*

<sup>562</sup> [2011] CoPLR Con Vol 717

<sup>563</sup> Speaking extra-curially, HH Judge Marshall QC (2012) has said that 'There is often no substitute for the value of actually seeing and assessing a person for oneself, but this should be viewed as an aid to assessing all the other evidence, medical and general.'

<sup>564</sup> [44], [51]

<sup>565</sup> *Re E (Medical treatment: Anorexia) (Rev 1)*, [102]

<sup>566</sup> See, for example, the case *EM v SC* [2012] EWHC 1518 (COP); [2012] All ER (D) 42, where a letter from a man's son was read out to him in court, which said that if his father came home he would not give him any support or help and would have nothing to do with him. EM's reaction was disbelief that the letter could have come from his son, which affirms that participation in court proceedings may in some cases be stronger confirmation of incapacity than capacity.

<sup>567</sup> [72]

autonomous person', 'it was indispensable for the judge to have at least a brief visual contact with the applicant, and preferably to question him'.<sup>568</sup> The ECtHR held that for a judge to decide the case on the basis of documentary evidence, without seeing or hearing the person, was unreasonable and in violation of Article 6.<sup>569</sup> In *X and Y v Croatia* the ECtHR held that 'judges adopting decisions with serious consequences for a person's private life, such as those entailed by divesting someone of legal capacity, should in principle also have personal contact with those persons.'<sup>570</sup> The court also emphasised that:

...at the end of the day, it is the judge and not a physician, albeit a psychiatrist, who is to assess all relevant facts concerning the person in question and his or her personal circumstances. It is the function of the judge conducting the proceedings to decide whether such an extreme measure is necessary or whether a less stringent measure might suffice. When such an important interest for an individual's private life is at stake a judge has to balance carefully all relevant factors in order to assess the proportionality of the measure to be taken. The necessary procedural safeguards require that any risk of arbitrariness in that respect is reduced to a minimum.<sup>571</sup>

These cases suggest that Articles 6 and 8 ECHR place the judges of the Court of Protection under an active duty to meet with P and come to their own conclusions regarding his capacity and the proportionality of any measures proposed in connection with him. There are differences between deprivation of legal capacity procedures, which these ECtHR cases concerned, and the kinds of financial and welfare decisions made in the Court of Protection. However, it is undeniable that even the most routine application for financial deputyship will have 'serious consequences for a person's private life' and hence may carry a requirement for personal contact.

Before we get too carried away believing that judicial contact with 'P' can resolve all our difficulties we should recall that even if a judge does meet with P, this does not place P on an equal footing in putting his case and asserting his mental capacity with other litigants. As observed earlier, much of the reason KK was found to have mental capacity was surely due to the skilful arguments put by her legal representatives. If a litigation friend is instructing a person's representatives to argue that they lack mental capacity, or for something which is contrary to their interests, who will work to present their oral evidence in the best possible light for minimising interferences with their personal preferences?

This concern would be addressed by the fourth proposal, that the role of a litigation friend should itself be transformed in the context of Court of Protection

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<sup>568</sup> [73]

<sup>569</sup> [73]

<sup>570</sup> [84]

<sup>571</sup> [85]

litigation<sup>572</sup> from one who represents P's interests, to one who puts to the court the strongest possible case that P has mental capacity, or - in the alternative – that what P wants is in his best interests.<sup>573</sup> This may seem rather radical to some, but in contrast with some interpretations of the requirements of Article 12 CRPD it appears rather conservative and would not go as far as many would like.

This approach would be likely to mean that litigation friends are required to argue cases which they feel are weak, or for outcomes which they regard as detrimental to P's best interests. Furthermore, this proposal would result in a greater volume of litigation in the Court of Protection if litigation friends were required to pursue cases which challenge best interests decisions on P's behalf that would currently be regarded as futile or not in P's best interests. However, this approach would ensure that the case for any interference under the MCA which P resisted would be thoroughly adversarially tested. It would mean any evidence that a person lacked mental capacity would always be contested before the court, even if there were no expert evidence to the contrary. Similarly, arguments that it was not in P's best interests to give effect to his wishes and preferences would be fully adversarially tested.

This approach would accord with the view that it is for the court, not litigation friends, to decide whether or not to accept expert evidence as to a person's mental capacity and best interests. It would also seem to accord with supported decision making approaches influenced by Article 12(4), which calls for 'measures relating to the exercise of legal capacity' to 'respect the rights, will and preferences of the person'. My proposal would not accord with approaches that suggest that a person's will and preferences should always be determinative,<sup>574</sup> because it would be open to the court to make an order which conflicts with them. However, this would guarantee the best possible resistance to this possibility under the MCA.

It might reasonably be asked what danger lies in litigation friends instructing solicitors in this fashion. Welfare litigation would not arise unless some party were advancing a case based on P's alleged mental incapacity and best interests. The Court of Protection must have regard to the overriding objective of 'ensuring that P's

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<sup>572</sup> I should stress that I am only advancing this argument in connection with Court of Protection litigation. There are other considerations in other types of legal proceedings, in particular the possibility of being awarded the costs of other parties – which do not pertain in welfare litigation at least in the Court of Protection. Negligence claims have been brought where claimants have argued that their solicitors allowed them to settle for too little in compensation claims and did not detect that they lacked the capacity to litigate (*Masterman-Lister v Brutton & Co*, and see also *Dunhill v Burgin* [2012] EWCA Civ 397). Similar arguments might pertain in certain other types of litigation, but I would hesitate to argue that here without more carefully considering the issues and context.

<sup>573</sup> In cases where P has no discernible wishes and preferences litigation friends would, of course, have to make the best argument they can on another basis. This might be either 'substituted judgment' where that is possible, or 'best interests' as under s4 MCA.

<sup>574</sup> Such an approach would appear to be taken by Dhanda (2006-7) and Minkowitz (2006-7).

interests and position are properly considered'.<sup>575</sup> If there were residual concerns that a person's interests were not adequately represented by those parties, it would be open to the court to instruct the OS as an 'advocate to the court'. This practice was common in cases heard under the declaratory jurisdiction where a person asserted that they had capacity and was not represented via a litigation friend.<sup>576</sup>

## CHALLENGES FOR REFORM OF THE COURT OF PROTECTION

In this chapter I have argued that people must be supported to challenge best interests decisions which engage their Article 8 rights if they disagree with them. I have argued that they should be entitled not only to participate in proceedings so far as they are willing to do so, but also to be supported by a litigation friend who represents their *subjective* interests – not their interests as construed by experts or others. I suggest that this is the only way in which we can rest assured that the basis for interventions premised upon a person's alleged mental incapacity are thoroughly adversarially tested, and hence best safeguarded against arbitrariness.

Suggestions of this nature would be likely to meet with considerable resistance from those familiar with the Court of Protection, in particular on the basis that they are impracticable. I fully acknowledge that the Court of Protection as it is currently composed would struggle to accommodate these proposals. The court is overworked as it is, and almost certainly could not cope with the increased volume of litigation this would entail. Participation is problematic when judges sit in regional courts which may present significant access problems for people with disabilities.<sup>577</sup> Currently the majority of cases, especially those concerning financial deputyship and other such matters, are heard 'on the papers', and so opportunities for P to participate in person would not exist. Legal advice and representation for P would need to obtain funding from some source. Currently financial cases are not eligible for legal aid, and so P's own resources could be depleted by litigation friends running 'futile' arguments. Welfare cases are more likely to obtain public funding, but in many cases arguments which advance P's subjective interests would not meet the LSC's 'merits test'. None of these obstacles are, I suggest, insurmountable *a priori*. However they would, I acknowledge, require radical and costly reforms to be overcome.

These are serious concerns. They suggest that the court as currently composed will struggle to accommodate the requirements of the ECHR that judges make efforts to meet P in cases which have serious consequences for their personal lives. The more radical suggestion that P be supported to challenge any best interests

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<sup>575</sup> Court of Protection Rules 2007 rule 3(3)(b)

<sup>576</sup> E.g. *Ms B v An NHS Hospital Trust; Re C (Adult: Refusal of Medical Treatment)*.

<sup>577</sup> In contrast, for example, with mental health tribunals which occur in the hospital where a person is detained.

decisions he disagrees with is even more challenging. This suggests that there is a fundamental tension between P's theoretical right to challenge interferences under the MCA, and the practical demands of ensuring that P is enabled to do so as fully as possible. Currently the status quo seems to be maintained through the fiction that wherever P wishes to challenge a major interference with his rights, he is able to do so. *Ex hypothesi*, evidence to the contrary would be unlikely to come before the courts. Unlike those subject to formal deprivation of legal capacity procedures in other jurisdictions, those who are alleged to lack capacity under the MCA are not subject to any formal bar to using the courts. Yet their rights to challenge decisions made under the MCA may still be 'theoretical and illusory' for the most part due to an accumulation of practical and procedural hurdles. The remote possibility of litigation acts as a safety valve for the most persistent to assert their rights, protecting the state from confronting the reality that the vast majority never could.

If the UK is to take steps in the direction of ensuring that people's rights to challenge decisions made under the MCA are 'practical and effective', they may well have to revisit the Law Commission's (1995: [10.3]-[10.8]) decision to prioritise the status of a court over the accessibility of a tribunal. Tribunals are by no means uncritically vaunted as the best way to guarantee fairness or positive experiences of tribunal users (see, e.g., the following writings on mental health tribunals: Bartlett and Sandland, 2007; Care Quality Commission and Administrative Justice and Tribunals Council, 2011; Horne, 2011; Machin and Richardson, 2000; Mental Health Act Commission, 2005; Munro, 2008; Perkins, 2003; Richardson and Machin, 2000; 1999). However they do overcome several of the concerns about the Court of Protection rehearsed here. It might be questioned whether or not tribunal hearings could accommodate Court of Protection welfare cases, which Munby LJ describes as having 'all the complexity of a heavy child care case but, in addition, the extra complexity of disputes about capacity and, sometimes, also about deprivation of liberty' (The Right Honourable Lord Justice (Sir James) Munby, 2011: 34). Yet there are those who suggest that they could (Jones, R., 2012; Mental Health Lawyers Association, 2011), and in light of these concerns this is surely an avenue worth pursuing through further research and investigation.

## 5.4 THE EFFICACY OF COMPLAINTS MECHANISMS AS A SAFEGUARD

The MCA code of practice suggests the use of complaints mechanisms to challenge decisions made under the MCA (Lord Chancellor's Office, 2007).<sup>578</sup> Local

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<sup>578</sup> See paragraphs [5.68], [10.15], [10.34], [10.37], [14.37], [15.12], [15.14]-[15.21], [15.23]-[15.32]



authority social services, NHS bodies<sup>579</sup> and care providers<sup>580</sup> are obliged to have complaints procedures in place. Complaints to NHS bodies and local authority social services must be made by the victim of the act or omission, or a person entitled to complain as a representative on their behalf.<sup>581</sup> Where complaints involve more than one authority they have a duty to co-operate together to coordinate investigation of the complaint.<sup>582</sup> The complaint must be resolved speedily and efficiently, within a maximum of six months.<sup>583</sup> If a complainant is dissatisfied by the response to their complaint then they can take the complaint to the Local Government Ombudsman (LGO) – for complaints about local authority social services and social care providers<sup>584</sup> - or the Parliamentary and Health Service Ombudsman (PHSO) if it is about a health service.

#### 5.4.1 THE ROLE OF OMBUDSMEN

Ombudsmen can investigate complaints into ‘maladministration’, which is a somewhat vague concept and subtly different to ‘unlawful’. The LGO (2008) describes the following as examples of maladministration which it could investigate:

- delay
- incorrect action or failure to take any action
- failure to follow procedures or the law
- failure to provide information
- inadequate record-keeping
- failure to investigate
- failure to reply

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<sup>579</sup> Through regulations issued by the secretary of state for health under The Health and Social Care (Community Health and Standards) Act 2003. The relevant regulations are The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 SI 2009/309 and The Local Authority Social Services and National Health Service Complaints (England) (Amendment) Regulations 2009 SI 2009/1768

<sup>580</sup> By r19 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 SI 2010/781

<sup>581</sup> Representatives may complain on behalf of a person where the person themselves has died, is a child, has appointed the representative to act for them, or the person is unable to make the complaint themselves because of a physical disability or because they lack capacity in the meaning of the MCA. Rule 5 The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 SI 2009/309.

<sup>582</sup> r9 The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 SI 2009/309

<sup>583</sup> r14 The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 SI 2009/309

<sup>584</sup> Historically the CSCI used to investigate complaints made against care providers, but ceased to do so in 2008. This was not the result of any legal change, but apparently resulted from the CSCI ‘realising’ it had no statutory powers to investigate complaints FOIA. The LGO was unable to investigate complaints into private care providers where the care had not been arranged by the local authority; however, s35 Health Act 2009 gave the LGO powers to investigate complaints in those settings as well.

- misleading or inaccurate statements
- inadequate liaison
- inadequate consultation
- broken promises

Ombudsmen investigate and report on complaints<sup>585</sup> and can make recommendations, including recommendations to compensate complainants.<sup>586</sup> The findings and recommendations of ombudsmen are not legally binding, although if a local authority chooses not to adopt the LGO's recommendations they must publish a statement to that effect in a local newspaper.<sup>587</sup> Former ombudsman Ann Abraham (2012: 93) has described the role of ombudsmen in today's administrative justice landscape as a 'muddle', one of a 'miscellany of institutions – alongside the quite separate but frequently overlapping regulators, auditors and inspectorates, not to mention the Equality and Human Rights Commission'. Nevertheless, as a free and independent source of scrutiny into the actions of local authorities and care providers, LGOs occupy a potentially very important role in effective enforcement of legal principles. It is important to note from the outset, however, that ombudsmen do not have many of the powers which make the Court of Protection such a potent safeguard – to require the production of reports as evidence, to make declarations as to a person's mental capacity and orders regarding their best interests. They might, however, recommend that an authority or provider revisit any defective assessment or decision making processes with regard to the principles of the MCA.

#### 5.4.2 PROBLEMS WITH LOCAL COMPLAINTS PROCEDURES

Detailed consideration of internal complaints procedures for local authorities and care providers is not within the scope of this thesis, although research on social work complaints procedures in Scotland identified several practical barriers. Like litigation, complaints procedures are inherently self-starting, meaning people with learning disabilities will either need to be able to make a complaint themselves or a representative must make one on their behalf. Gulland (2007: 252-7) found that people

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<sup>585</sup> Ombudsmen can also initiate thematic investigations of its own accord in areas where it has particular concerns, it is – according to Abraham, a former Ombudsman – 'a system of justice that is about more than the individual antagonism of the adversarial litigation process: it is a system that is inquisitorial and reflexive, public and rights-based, as much about constitutional entitlement as consumer satisfaction'. This is, Abraham notes, 'especially salient when considering the situation of some of the most socially disadvantaged, including those who are detained in prison, psychiatric institutions and care homes and so are among the least likely to have the opportunity to alert the Ombudsman to their concerns' (Abraham, 2012: 95-6).

<sup>586</sup> For the LGO see Local Government Act 1974 and for the PSHO see the Health Service Commissioners Act 1993, as amended by the Health Service Commissioners (Amendment) Act 1996.

<sup>587</sup> s31(2D)-(2H) Local Government Act 1974

were less likely to complain when they were 'physically or emotionally drained'. Some potential complainants were put off by a perceived necessity to put the complaint in writing – particularly where they had concerns about their spelling or had visual impairments. A person who had difficulty making a phone call without assistance was entirely reliant on professionals to help him to complain as he had no friends or family to support him. An advocate raised concerns that people in hospitals or residential care settings might have difficulty getting access to the telephone. Gulland concluded that 'one obvious answer to this problem is advocacy', but noted that advocacy services were 'thin on the ground', and that many of the same practical obstacles pertained to contacting advocacy services in the first place.

A government consultation found that NHS and social care complaints procedures were 'too prescriptive and inflexible, not meeting the needs of the person making the complaint'; too 'fragmented' and lacked 'the proper emphasis on resolving problems locally, quickly and effectively' (Department of Health, 2008e: 5). Clements and Thompson (2011: [26.11]) observe that 'it remains to be seen' whether reforms resulting from this consultation will improve matters. Mandelstam (2009a: [4.5]) highlights that law courts have pointed out that complaints procedures are unsuitable for resolving matters of law, and comments that the LGO has 'repeatedly found that complaints procedures are in practice too often ineffective and long-winded'. From a republican perspective, internal complaints mechanisms do not satisfy the requirement of enforcement from an external and independent body (Lovett, 2010a; Pettit, 1997b). Consequently, the role of Ombudsmen is essential in providing a form of external adjudication.

#### 4.4.3 THE ACCESSIBILITY OF OMBUDSMEN COMPLAINTS PROCEDURES

Despite their limited powers and the concerns discussed above, there are aspects of Ombudsmen complaints procedures which could make them a fairly attractive remedy for people with learning disabilities. Unlike litigation, a person does not have to make a complaint through a third party if they are deemed to lack mental capacity, and so the subject matter of the complaint can be defined by them not others. Complaining to ombudsmen does not necessarily require a person to procure expert legal advice to help them navigate the system. The LGO website states that they have arrangements to help people make a complaint if they have difficulty using the service, and give as examples providing materials in Braille, Easy Read guidance or as a voice recording.<sup>588</sup> The Easy Read guidance states 'It is best if you call us on the phone and tell us about your complaint. We can take down the details over the phone so you do

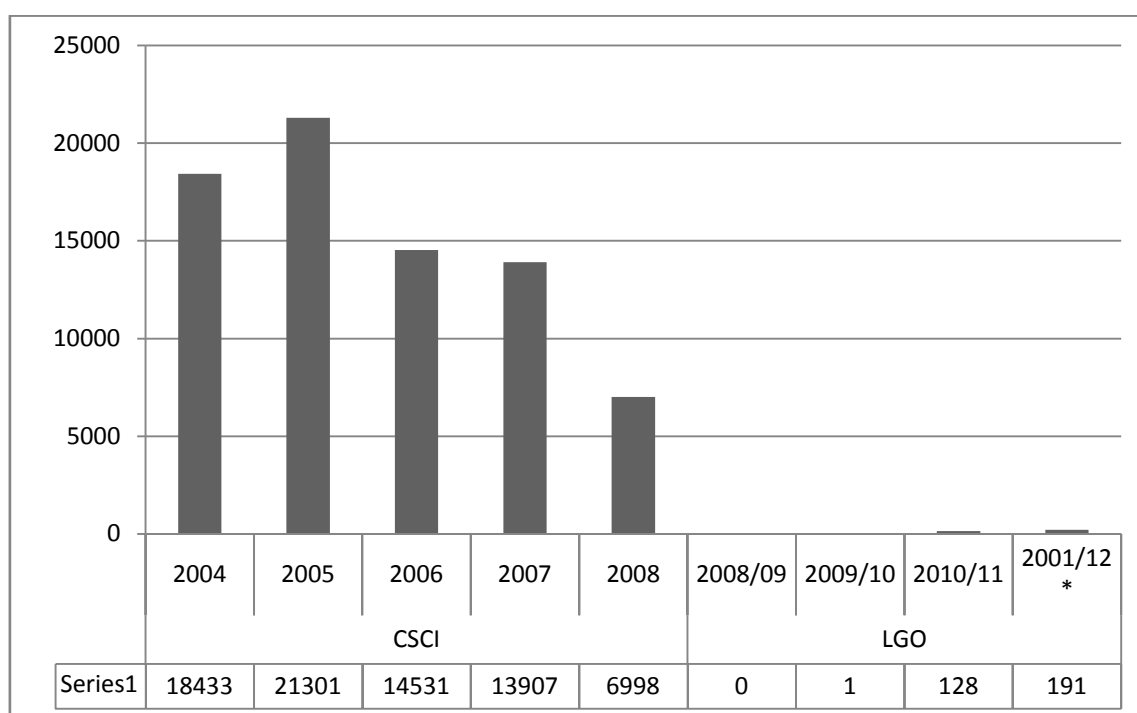
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<sup>588</sup> <<http://www.lgo.org.uk/making-a-complaint/>> [accessed 04 September 2012]

not have to write it down' (Local Government ombudsman, 2010: 7). This method may not be accessible to all complainants,<sup>589</sup> however it is significantly more accessible than attempting to navigate complex Court of Protection application procedures.

Despite the relative accessibility of Ombudsmen, they appear to receive relatively few complaints about adult social care services. For example, Figure 1 shows data obtained under the FOIA from CQC and the LGO which suggests that the volume of complaints against care homes declined steeply when LGO assumed responsibility for this role from the CSCI<sup>590</sup> (FOIA #10; #11):

**Figure 1 Volume of complaints about care providers received by the CSCI and LGO<sup>591</sup>**



Because the volume of complaints to the CSCI was initially so high, it must be assumed that the decline in the number of complaints is in some way specific to its transfer to the LGO – rather than difficulties initiating complaints in general. One reason may be that not all potential complainants are aware of the Ombudsman’s role. In email correspondence<sup>592</sup> LGO officials confirmed that government restrictions had severely limited their ability to publicise their new role. It is disappointing that more people have not been able to make use of ombudsmen complaints procedures, given

<sup>589</sup> Including those with learning disabilities which impair communication; they might require special assistance to make a complaint.

<sup>590</sup> See n584, above

<sup>591</sup> Only partial data is available for 2011-12; it is correct up to February 2012. Data may be incomplete, as not all complaints about adult care services were ‘assigned’. See Table 8, Appendix B, for a more detailed breakdown of the LGO data.

<sup>592</sup> Dated 9 February 2012 (FOIA #10)

they offer a potentially much more accessible route to independent investigation and arbitration of some issues connected with the MCA than the courts.

#### 4.4.4 OMBUDSMEN AND THE MENTAL CAPACITY ACT

Although departure from the procedures required by the MCA is likely to result in maladministration, Ombudsmen have no obvious source of authority to revisit an assessment of mental capacity, nor do they have powers to make declarations regarding a person's best interests. This is a significant limitation on the extent to which they can adjudicate disputes around mental capacity and best interests, or operate as a 'review' for decisions made under the Act. Nevertheless, they can draw attention to the Act's principles where appropriate.

To understand the way in which Ombudsmen work with the MCA, I undertook a review of all published LGO investigations which referenced the MCA. All those which I could locate are summarised in Study B5, Appendix B. The LGO also kindly disclosed to me three investigation reports which were related to the DoLS, and gave permission for them to be published in this thesis.<sup>593</sup>

Scrutiny of these investigations reveals that the MCA intersects in numerous ways with the LGO's work, not all directly related to the concerns under discussion here.<sup>594</sup> Very often the ombudsmen have been critical of lapses in assessment and consultation duties related to the MCA. The LGO found maladministration where a person with dementia was moved between care services without a capacity assessment and without following the best interests consultation requirements. According to the LGO, this denied 'the family the opportunity to make best interest representations on her behalf at the earliest opportunity and overlooked considering whether advocates should have been involved'.<sup>595</sup> Maladministration was also found where a mental capacity assessment was not conducted in a timely fashion where a care home had prevented a woman from visiting her mother. As a consequence of the delay, by the time the daughter visited her mother, she was no longer able to recognise her.<sup>596</sup> Interestingly, the LGO made no reference of the need to bring disputes of this nature before the Court of Protection. Maladministration was found where a council failed to review and record why a man 'was being effectively detained in unsuitable, locked accommodation' and failed to locate suitable permanent accommodation (Local

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<sup>593</sup> See Study B7, Appendix B

<sup>594</sup> For example, the LGO has considered a person's mental capacity to understand the terms of a grant from the LGO, and the mental capacity of people who are the subject of bankruptcy proceedings initiated by a council or whose neighbours have made complaints about their behaviour. See Study B7, Appendix B, for summaries of these cases.

<sup>595</sup> *Bristol City Council* 2011 (09/005/944)

<sup>596</sup> *Leeds City Council* 2011 (10/012/561)

Government Ombudsman and Parliamentary and Health Service Ombudsman, 2011: [103]).

Like the authors of Serious Case Reviews (SCRs), discussed in Chapter 4, the ombudsmen have also criticised care providers and authorities for exhibiting excessive deference to a person's wishes and preferences without considering whether they might lack mental capacity. The LGO and the PSHO were critical of a community mental health team and local authority for assuming that a man 'had at all times the capacity to make decisions in relation to his day-to-day life', without his mental capacity being formally 'tested'. They were critical of 'a culture which emphasised the individual's right to live in the way they chose', and a failure to pursue concerns about his wellbeing through the framework of the MCA or use of guardianship (Parliamentary and Health Service Ombudsman and Local Government Association, 2011). Council care workers have been criticised for not intervening to prevent a woman with dementia from overheating and dehydrating in hot weather through over-exercise, and not opening windows, because 'they had to take into account Mrs Nash's wishes.' The LGO found maladministration because 'while it was clearly known to the Council that Mrs Nash lacked capacity always to take decisions in her best interests, the Council did not communicate this to the care workers who would deliver her care.'<sup>597</sup>

These cases suggest that the ombudsmen are able to look into concerns where there are complex hierarchies of responsibility and control between providers and authorities. This is a clear strength of passing the responsibility for investigating complaints from the regulator – who can only consider the role of providers – to the ombudsman. The ombudsmen appear capable of highlighting deficiencies in the processes connected with the MCA. This is of clear importance where providers and authorities have not even complied with the MCA's requirements for assessment and consultation, nor recorded the results of these appropriately. However, as suggested at the outset there is little evidence that they would be able to review the content of a mental capacity assessment or the outcome of a best interests decision where it has taken place. This limits the extent to which a person who is alleged to lack mental capacity could use the Ombudsmen complaints procedures to challenge interferences where the MCA's procedures have been followed, but where they dispute its substantive interpretation.

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<sup>597</sup> *Worcestershire County Council 2011 (09/013/172)*

## 5.5 THE EFFICACY OF REGULATION OF CARE SERVICES AS A SAFEGUARD

Complaints mechanisms and litigation, as Munro (2012: 911-2) writes, 'rely heavily on dedicated and hard-working complainants willing to sacrifice considerable resources to the cause of seeing their rights protected' where 'These resources are especially scarce for people with mental disabilities'. This is supported by the evidence presented here which suggests that people with mental disabilities experience considerable difficulties accessing the Court of Protection and complaints procedures. Regulation may provide an important safeguard where opportunities for pursuing individual complaints are limited.

In the context of institutional care, Munro suggests that regulatory inspection is 'the most effective mechanism available for raising standards and ensuring that the worst practices are outlawed are domestic and supranational inspection regimes' (p904-5). The view that regulation is a more effective way to safeguard the rights of care institution residents than litigation appears to be broadly shared. For example, regulation by the CSCI was one reason given by Lord Scott in *YL v Birmingham City Council* for care home residents not needing the direct protection of s6 HRA. In a recent study of lawyers' interpretations of 'deprivation of liberty' Cairns et al (2011b: 235) reported that some lawyers believe that:

An alternative approach to widespread use of DoLS might involve better inspection and regulatory regimes for all non-objecting incapacitated individuals in hospital and care homes aimed at ensuring good care really is provided. The DoLS could be more narrowly targeted "towards the real ills".

Without wishing to suggest that regulation is unimportant, or that it offers no protection, I believe there are dangers in overstating what can be achieved via regulatory approaches. They are certainly no substitute for ensuring there are accessible procedures whereby an individual – or others on their behalf – can challenge decisions made by a care provider under the MCA or which otherwise affect their human rights. This section will explore some of the strengths of regulatory protection, but cautions that they are not a panacea for the issues of concern here.

### 5.5.1 GENERAL LIMITATIONS OF REGULATORY APPROACHES

The Care Quality Commission (CQC) was created by the Health and Social Care Act 2008 and amalgamated many staff and functions from three predecessor bodies: the Commission for Social Care Inspection (CSCI), the Healthcare Commission (HCC) and the Mental Health Act Commission (MHAC). Like the CSCI and HCC, the CQC is responsible for registering and inspecting health and social care providers, but

it also retains the monitoring and visiting functions of the MHAC in respect of patients detained under the MHA<sup>598</sup>. As a regulator, CQC enforces 'essential standards' for compliance laid down in regulations<sup>599</sup> (Care Quality Commission, 2010a; c). A main statutory objective of the CQC is 'the improvement of health and social care services'.<sup>600</sup> The CQC must have regard to the views of the public about services, the experiences of people who use services and their families and friends, the 'need to protect and promote the rights of people who use health and social care services' and in particular 'the rights of children, of persons detained under the Mental Health Act 1983, of persons who are deprived of their liberty in accordance with the Mental Capacity Act 2005... and of other vulnerable adults'.<sup>601</sup>

The first years of the CQC has been rocky for regulator, providers and service users alike. The CQC's budget represented a 32% reduction of the combined budget of its predecessors, and the overall regulatory and visitation workforce was reduced by 28% (Care Quality Commission, 2010b: 17).<sup>602</sup> The CQC took the decision to re-register all health and social care services, which had a significant impact on their ability to inspect against compliance standards (Controller and Auditor General, 2011; Department of Health, 2012c). The CQC's approach to regulation in the UK has been heavily influenced by the 'Hampton Principles', which sought to reduce the 'administrative burden' of regulatory inspections by reducing inspections where risks were low, increasing them where risks were high, and applying tougher and more consistent penalties where necessary (Hampton, 2005). Consequently, the CQC adopted a 'risk based' approach to regulation which had been trialled in different ways by its predecessors in the HCC and the CSCI.

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<sup>598</sup> s52 Health and Social Care Act 2008. The CQC is now part of the National Preventive Mechanism for monitoring the conditions of detainees in accordance with OPCAT (United Nations, 2006b).

<sup>599</sup> The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 SI 2010/781

<sup>600</sup> s3(2) Health and Social Care Act 2008. There seems to have been some confusion about the CQC's improvement role for its previous Chief Executive Cynthia Bower, who said that the CQC could not be 'an improvement agency and a control agency' and had to settle for 'policing the bottom line' (Calkin, 2012). It is unclear how Bower thought this approach was compatible with the CQC's statutory objectives, and the new CEO David Behan said that CQC had been 'chased off the territory of improvement' and indicated that it would be at the heart of CQC's renewed strategy and mission statement (Samuel, 2012a).

<sup>601</sup> s4(1) Health and Social Care Act 2008

<sup>602</sup> See Figure 7,

Figure 8 and

Figure 9, in Appendix B, for graphs showing the year on year reduction in expenditure on regulation and inspection of health and social care services.



The CQC's approach to regulation has been subject to sustained criticism on a variety of fronts, many expressed in the context of the CQC's failure to respond to whistleblower allegations at Winterbourne View hospital (Flynn, 2012; House of Commons Health Committee, 2011b; a; Mencap and Challenging Behaviour Foundation, 2012a; Rosebush, 2011). The regulatory approach was also scrutinised by a public inquiry into serious neglect and poor standards at the Mid Staffordshire Hospital (Mid-Staffordshire NHS Foundation Trust Public Inquiry, 2012).<sup>603</sup> Although not all these criticisms can be considered in detail here, many of them impact upon how effectively CQC can enforce the provisions of the MCA in adult social care services and protect related rights.

As the CQC itself notes in its Guidance for Providers on the MCA, it 'has no direct powers to enforce the MCA' (Care Quality Commission, 2011h: [6])<sup>604</sup>. However, CQC suggest that the following 'essential standards' are relevant to enforcing the MCA:

- Outcome 1: Respecting and involving people who use services<sup>605</sup>
- Outcome 2: Consent to care and treatment<sup>606</sup>
- Outcome 4: Care and welfare of people who use services<sup>607</sup>
- Outcome 14: Supporting workers<sup>608</sup>

The CQC has – with the input of the EHRC – read human rights values into the 'essential standards' (Care Quality Commission and Equality and Human Rights Commission, 2011b; a; c). As noted in Chapter 3, their interpretation of key rights such as Article 8 is in many ways more expansive than the approach taken by the courts.

However, no matter how aspirational its values or effective its methodology, the CQC is constrained by its remit as to the matters it can investigate. It is a regulator of providers, not commissioners of care,<sup>609</sup> and so is by and large unable to tackle issues

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<sup>603</sup> Please note that at the time of writing the Chair of the Mid Staffordshire NHS Foundation Trust Public Inquiry, Robert Francis QC, had yet to publish his report. However, evidence of witnesses, and submissions of counsel to the Inquiry, can be found on the website: <http://www.midstaffpublicinquiry.com/> [accessed 19 January 2013]

<sup>604</sup> The MCA code of practice was published before the CQC was established. It still recommends people go to the CSCI if they wish to complain about care providers (Lord Chancellor's Office, 2007: [14.20]).

<sup>605</sup> r17 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 SI 2010/781

<sup>606</sup> r19 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 SI 2010/781

<sup>607</sup> r9 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 SI 2010/781

<sup>608</sup> r23 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 SI 2010/781

<sup>609</sup> The CQC, and its predecessor the CSCI, did used to assess the performance of local authority adult social care services, however the Minister for Social Care took the decision to

that relate to a person's trajectory into – or out of – a particular service. This is a serious shortcoming in situations where a person may be unhappily or inappropriately placed in a service – a key concern considered in Chapters 2 and 4 – which gives rise to issues which may be challenging for a service to manage. A good example of this is the situation which arose in *C v A Local Authority*<sup>610</sup>, where the school simply could not accommodate C's need to be naked and sole-resident accommodation had to be sought instead. CQC could not regulate out of area placements, nor situations where a provider was inadequately resourced by commissioners to meet all of a person's eligible needs and address any human rights issues which arose as a result of the placement or restrictions.<sup>611</sup> Matters which raise questions of whether or not a service is appropriately commissioned are unlikely to be tackled through regulatory approaches which focus on that which remains within the control of providers.

## 5.5.2 DETECTION OF NON-COMPLIANCE WITH REGULATORY STANDARDS

Self-evidently, in order for CQC to act upon non-compliance with regulatory standards, it must first become aware of it. CQC relies upon four main sources of information in order to monitor a provider's compliance: information provided to the CQC by the service provider; information gathered by CQC inspectors on site visits; information volunteered to the CQC by 'whistleblowers' and others; and statistical information collated from other data sources and compiled to create Quality and Risk Profiles (QRPs)<sup>612</sup>. Each of those methodologies has been subject to criticism on the basis they could fail to detect poor care standards and abuse and neglect of service users, especially in connection with the social care sector.

### 5.5.2.1 SELF-ASSESSMENT

CQC's Provider Compliance Assessment tool is a 'self-assessment tool for [providers] to monitor [their] compliance with the essential standards of quality and safety' (Care Quality Commission, 2010g: 4). Providers are encouraged to use the tool 'on a regular basis to self-assess if you wish', but if CQC is conducting a planned review of compliance or responding to concerns 'Where we have gaps in the

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strip them of this role in 2010, calling it 'unnecessary bureaucracy' (Dunning, 2010). The Local Government Association (2012) set up a program entitled 'Towards Excellence in Adult Social Care', said to consist of 'regional work; robust performance data; self-evaluation; and peer support and challenge', to replace the performance assessments. At the time of writing, their precise methodology and role appears to be in development still.

<sup>610</sup> This case is discussed in more detail in Chapter 4.

<sup>611</sup> For example, provision to assist a person to visit family or access community based activities. Or unusual circumstances such as arose in *Local Authority X v MM and KM*, where a local authority had to put in place arrangements to facilitate a person's sexual relationship.

<sup>612</sup> CQC has produced guidance on the statistical methodology, sources of data and development behind QRP's (Care Quality Commission, 2011j; 2012e; 2011c).

information we hold about a regulated activity at specific locations, we may ask you to send us parts of the PCA' (p4, 5). According to an internal document sent by CQC middle managers to its Chief Executive, the quality of information supplied by self-assessment is often poor (Mid-Staffordshire NHS Foundation Trust Public Inquiry, 2012: [35]). Prior to its amalgamation into the CQC, the MHAC expressed concern that their experience showed 'considerable and dangerous gaps between self-assessment and reality' (Mental Health Act Commission, 2008b: 18). The EHRC (2011a), the Public Accounts Committee (2012), the House of Commons Health Select Committee (2011a), several witnesses to the Mid Staffordshire NHS Foundation Trust Public Inquiry (2012), the charities Age Concern (2009), Counsel and Care (2010) and the Relatives and Residents Association (House of Commons Health Committee, 2011a) have all expressed concern that self-assessment may not detect failings within a service and hear the concerns of service users.

The reasons for this are self-evident. Care providers who do not fully understand what regulatory compliance looks like, will not detect failings through self-assessment. Providers who are motivated to conceal breaches of regulatory standards from CQC, will not report them through self-assessment. A CQC inspector interviewed for this research observed that good services, who are more aware of their shortcomings and honest enough to raise them, will be penalised by self-assessment approaches in contrast with those who are unaware of difficulties or conceal them. Consequently, self-assessment is unlikely to identify providers who do not understand the provisions of the MCA, or who are not upfront about departures from good practice. This is a good example of why the externality of enforcement mechanisms is a fundamental principle for securing republican liberty (Lovett, 2010a: 100; Pettit, 1997b: 155). It should, therefore, be a matter of concern that 'regulation of health and adult social care is falling increasingly on the providers of these services' (Controller and Auditor General, 2011: 11).

## RISK RESPONSIVE REGULATION

At a recent CQC event on restrictive practices in care settings the Chief Inspector of Prisons, Nick Hardwick (2012) noted four key reasons why closed institutions 'go wrong' in his experience:

1. The power imbalance between detainee and custodian;
2. The disparity in credibility between custodian and detainees, who are usually drawn from stigmatised social groups, means their reports of what has happened to them are often not believed;
3. In closed institutions, outsiders cannot see what is going wrong;

4. Those working within closed institutions become habituated to its practices and customs, and they come to be seen as 'normal'; the 'vision of staff is also restricted by the walls'.

Hardwick emphasised that inspectors play a key role in casting a less habituated set of eyes over a service and its practices, confirming the credibility of reports of detainees, and rectifying wrongs that have arisen as a result of power imbalances. Hardwick described a key function of prison inspection as giving governors information on the discrepancies between the 'virtual prison the governor thinks he is running' and what they have seen on the ground. For the purposes of preventing ill treatment, the importance of such independent monitoring of places of detention, defined as places which a person is not free to leave, is a central insight of the UN Optional Protocol on the Convention Against Torture ('OPCAT', United Nations, 2006b).

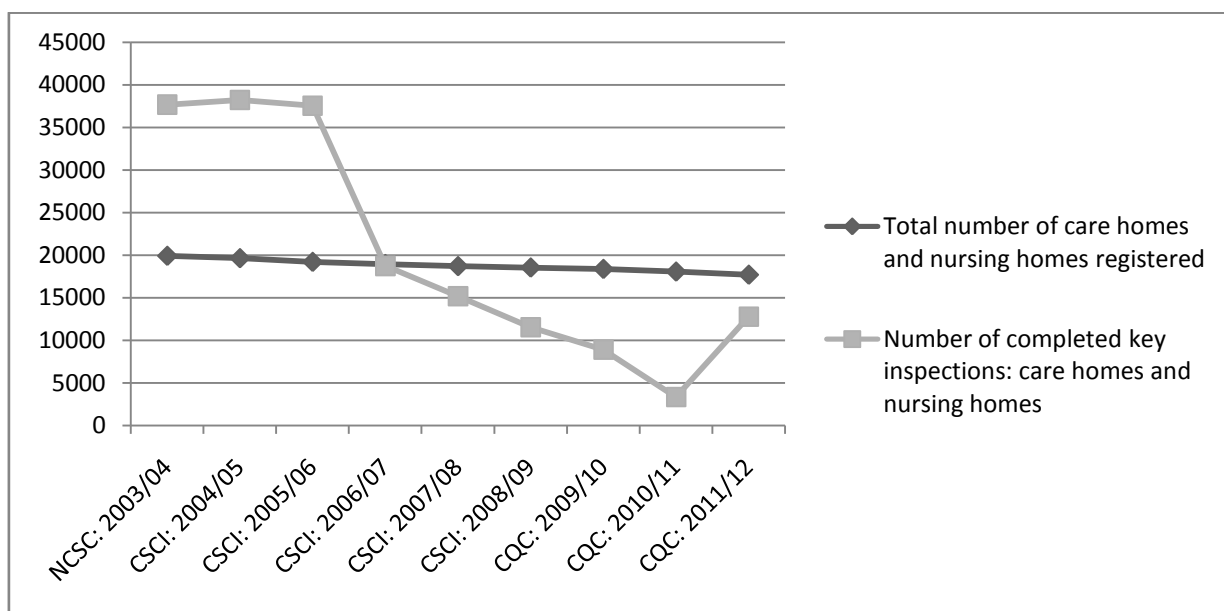
Despite these, perhaps obvious, advantages of independent inspection of care services, over the last decade regulatory inspection came to be seen as a 'burden' for providers of services which should be eased (Hampton, 2005). A reduction in social care inspection under the Coalition government has achieved a high profile in the national media (Hari, 2011; Hill, 2010; O'Murchu, 2011; Pitt, 2011a), but this trend can be traced much further back in both health and social care. Following a government consultation (Department of Health, 2006a), a requirement to visit registered care services twice annually<sup>613</sup> was replaced by new regulations<sup>614</sup> which reduced inspection frequencies to once every three years. The results were striking:

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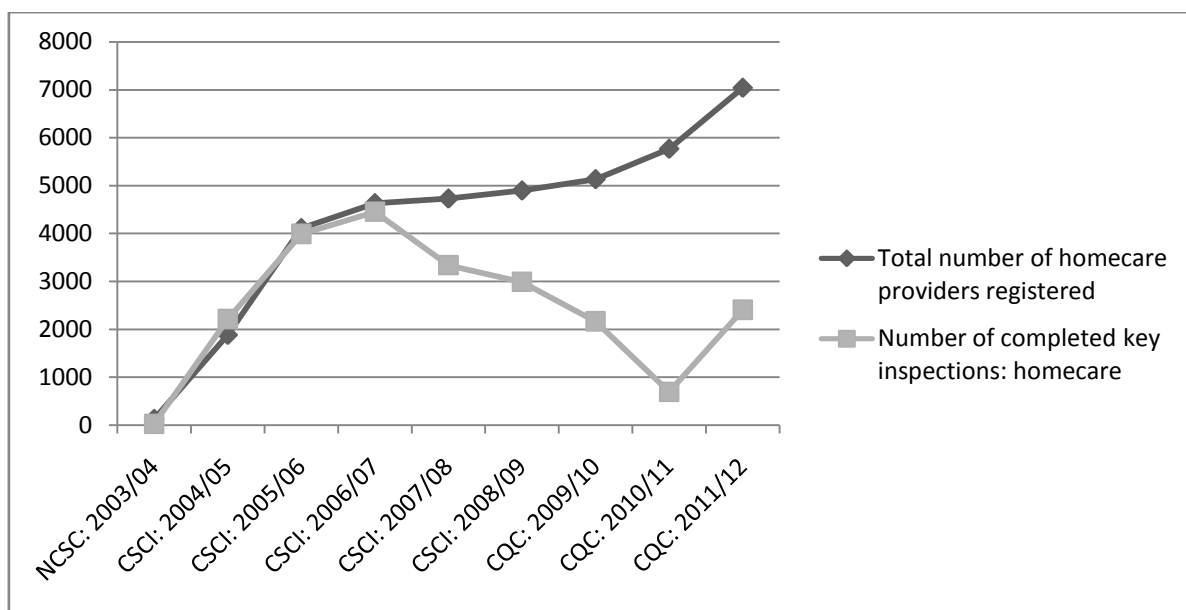
<sup>613</sup> r6 The Commission for Social Care Inspection (Fees and Frequency of Inspections) Regulations 2004 SSI 2004/662

<sup>614</sup> The Commission for Social Care Inspection (Fees and Frequency of Inspections) Regulations 2007 SSI 2007/556

**Figure 2 Residential care services registered and inspected each year (NCSC, CSCI and CQC), 2003-2012**



**Figure 3 Domiciliary care services registered and inspected by NCSC, CSCI and CQC, 2003-2012**



The Health and Social Care Act 2008 established no minimum inspection frequency for care services, and some care services – including supported living services – are not subject to regulatory inspections on site at all.<sup>615</sup>

<sup>615</sup> This is because supported living services are technically domiciliary care services in a person's own home. CQC has no rights of access to a private home, and so it regards itself as unable to visit service users there. To the best of my knowledge, CQC has never tried a 'by invitation' approach to supported living and domiciliary care services. Failure to inspect supported living services where people are not free to leave may be a violation of the OPCAT. The Department of Health and Ministry of Justice have been aware of this potential violation

In order to 'target' inspection resources CQC and its predecessor inspectorates used a 'risk based' approach to regulation. The CSCI and the HCC used different models. The CSCI's approach to risk targeting was based on a methodology of rating services ('poor', 'adequate', 'good' or 'excellent') and visiting poorer services more frequently, however this rating system was discontinued by the CQC (2010d). Instead CQC has looked to adopt an approach modelled on the HCC's statistical modelling of risk, by developing 'Quality and Risk Profiles' (QRPs) for each service. A key difficulty for adult social care has been the absence of good quality data to construct such indicators (Controller and Auditor General, 2011: 11).<sup>616</sup> Furthermore, a 'statistical' approach will only incorporate data on what can be measured statistically, and may miss important qualitative indicators of non-compliance with regulatory standards. Powerful examples of this come from the failures of QRPs in Winterbourne View hospital (FOIA #5) and Mid Staffordshire NHS Foundation Trust (Mid-Staffordshire NHS Foundation Trust Public Inquiry, 2012) to detect any elevated risks in those services. Meanwhile families of patients in those services had serious concerns about the care of their relatives (Flynn, 2010: 18-9).

This is not to suggest that QRPs are entirely useless. Studies of the HCCs statistical indicators show that inspections of the 10% 'highest risk' services were twice as likely to find non-compliance with standards than a randomly selected sample of 10% (Bardsley et al., 2009; Spiegelhalter et al., 2012). However, some elementary maths reveals that if only 10% of high risk services, and 10% of services selected at random, are subject to a compliance inspections, over 70% of non-compliant service would remain undetected.<sup>617</sup> Consequently, under this 'targeted' approach to inspection, the majority of non-compliant services would remain registered and publicly declared compliant. The advocates of QRPs do not discuss this, but as numerate researchers and regulatory experts they must be aware of this fact.

The reality of a shift towards 'targeted' use of inspection resources in social care was a dramatic decline in the use of inspection at all between the years 2007-11.

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since before the formation of CQC (Mental Health Act Commission, 2008b: [3.33]), but has yet to take any action on this issue.

<sup>616</sup> The size of social care services, in contrast with larger health services, may also be problematic as variations in statistics such as mortality rates will be far less robust indicators of risk (or the absence of risk) in a service with ten users than in a hospital with hundreds of thousands of patients.

<sup>617</sup> Bardsley reported that 26% of the 10% 'most risky' hospitals were non-compliant, whereas only 13% of those randomly selected were. With a total of 567 hospitals overall, it can be calculated that the inspections detected approximately 22 non-compliant hospitals; however, 13% of the uninspected hospitals were also be non-compliant based on the rate from the random sample. This means that of an estimated total of 81 non-compliant hospitals, only 22 (27%) were actually detected through inspection – the rest would have been registered as compliant, as self-declared by providers.

During 2010-11, the proportion of services reviewed<sup>618</sup> by CQC reached rock-bottom; fewer than 7% of all services for people with learning disabilities were inspected that year (FOIA #8).<sup>619</sup> During that year CQC came in for sustained criticism for its inaction over whistleblower allegations at Winterbourne View (Flynn, 2012), its methodology and executive were heavily criticised by witnesses at the Mid Staffordshire NHS Foundation Trust Public Inquiry (2011a; b; c; d; e; f; 2012). The National Audit Office (Controller and Auditor General, 2011), the House of Commons Public Accounts Committee (Public Accounts Committee, 2012), the House of Commons Health Committee (2011b; a) and the Department of Health (2012c) all heavily criticised CQC for a range of failings, including the failure to prioritise inspection over the bureaucratic and administrative task of re-registering providers.

In response to concerns about falling inspection frequencies, the CQC's former chief executive, Cynthia Bower, promised 'to put our boots on the ground,' and doubt inspection frequencies (Samuel, 2011a) and asked the government for more money (Pitt, 2011b). The government awarded CQC one-third less than it asked for,<sup>620</sup> and although CQC managed to increase the volume of inspections to 62% of all services during 2011-12 (FOIA #9) its new chief executive David Behan has warned that annual inspections of all services are not sustainable (Calkin, 2012). Instead, CQC is exploring a 'differentiated approach' with some services being inspected more frequently (Care Quality Commission, 2012c; Samuel, 2012a). Figures within CQC now appear to recognise 'institutional' services for people with learning disabilities are 'inherently risky' (Samuel, 2011a), however it is unclear whether they also include community based services in this category, and institutional services for other groups with mental disabilities. At present, the future of inspection of adult learning disability services looks uncertain.

## WHISTLEBLOWERS

Where a service is non-compliant but has not volunteered to CQC information which might reveal this, it is possible that 'whistleblowers' – either staff members, service users, or relatives or professionals visiting a service – might alert the CQC to difficulties. Senior CQC figures have indicated that they regard whistleblowers as an important source of information about compliance which they can rely upon where self-assessment falls short (Brindle, 2011; Care Quality Commission, 2011a; Hill, 2010). In response to criticisms of CQC's failure to formulate a whistleblower policy (Mid-

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<sup>618</sup> Not all reviews would necessarily entail an inspection, although CQC affirm that the majority of them would.

<sup>619</sup> In 2010-11 CQC reviewed 18% of nursing homes, 10% of residential care homes, 5% of domiciliary care agencies and 14% of independent healthcare and NHS services (FOIA #8).

<sup>620</sup> CQC had asked for £15m (Pitt, 2011b), but the Department of Health awarded it £10m (Samuel, 2011b).

Staffordshire NHS Foundation Trust Public Inquiry, 2012: [147]-[148]), and to act upon the concerns of whistleblowers in relation to Winterbourne View hospital (Flynn, 2012), a whistleblower helpline for NHS staff was extended to adult social care (Department of Health, 2011c).

Whilst clearly the concerns of whistleblowers are a valuable source of information and should be acted upon, over-reliance on whistleblowers to prompt action and make good a shortfall in inspection activity is problematic. Very often failings occur because staff themselves are unaware of care standards. Furthermore, as a highly vulnerable workforce, health and social care staff may – with good reason – fear retribution and difficulty securing future employment if they make their concerns known to employers (Public Concern at Work, 2008; 2011).<sup>621</sup> Not all service users will have regular contact with family or friends, a situation which is made worse by regular placement of adults with learning disabilities far from their home areas (Mencap and Challenging Behaviour Foundation, 2012a; Whelton, 2009). Family and friends may not reliably recognise poor care standards, or see what goes on behind the scenes in a care service. Many of the ‘low level’ interferences with the autonomy and wellbeing of adults with learning disabilities, for example excessively restrictive rules and regimes, may not be considered of sufficient severity for ‘whistleblowing’ to the regulator. Furthermore, there may be cultural expectations among staff and even among other visitors to services that adults with learning disabilities *should* be subject to rules for the benefit of their health or morals. By contrast a regulatory inspector, as somebody who should be familiar with policy and standards in the field, should recognise that unjustified restrictions are – in theory at least – unacceptable in the modern social care landscape.

### 5.5.3 QUALITY OF JUDGMENTS BY CQC INSPECTORS AROUND COMPLIANCE WITH THE MENTAL CAPACITY ACT

On the basis of evidence gathered through feedback from providers, whistleblowers and inspection, CQC inspectors must make judgments as to whether or not a service is compliant with regulatory standards. These judgments are dependent both on CQC compliance inspectors’ knowledge of the service, and their own personal skills and expertise in relation to the sector. Unfortunately, the CQC restructured its ‘field force’ (compliance inspection workforce) so that compliance inspectors no longer specialised in inspecting a particular type of service, but inspected all types of services registered with CQC. Rather than specialists in particular fields of health or social care,

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<sup>621</sup> Based on my own experience of whistleblowing in social care services, a key area of concern for agency workers would be the loss of any particular placements they raised concerns about with their agency. People whose employment itself is threatened may be concerned that they would not secure the requisite references for future employment.



CQC inspectors were to be 'professional regulators' (Mid-Staffordshire NHS Foundation Trust Public Inquiry, 2012: [35]).<sup>622</sup> In an interview for this research, a CQC inspector with a background in social care described being required to inspect dental practices, GP's surgeries, ambulances and commented that it could be embarrassing to go out and judge the compliance of services that are very specialist. They stated 'at the moment I feel I do not have the skills to do this', echoing the concerns of whistleblowers among CQC's own staff about the training and expertise of inspectors at the Mid Staffordshire Inquiry (Mid-Staffordshire NHS Foundation Trust Public Inquiry, 2011c).

Because the practical application of the MCA and human rights standards can be closely interlocked with understanding the specialist needs of people with disabilities and best practice in the field, expecting a generalist regulatory workforce to identify human rights violations and breaches of the MCA seems flawed. Again, the case of *C v A Local Authority* is a good example of where human rights concerns arose, but identifying them as such and making recommendations for changes would have required considerable knowledge of best practice for supporting C's particular needs. CQC do have specialist expert inspectors, but according to a recent report by the House of Commons Health Committee (2012: [44]) they have not been used in 87% of inspections since the resource became available.

Even with specialist expertise, assessing compliance with the details of MCA procedures – ensuring a person has been supported to make a decision for themselves as far as possible, ensuring their family have been consulted for best interests decisions – seems likely to require time commitments for individual service users which regulatory inspectors are unlikely to have. Although it is not stated anywhere in the CQC's guidance, it seems extremely unlikely – and perhaps inappropriate – that a CQC inspector would themselves undertake to assess a person's mental capacity or come to a view on their best interests. CQC's (2011h) own guidance on how it will monitor the MCA suggests it will look at records of capacity assessments and best interests decisions, and will ask staff about their knowledge of the MCA and implementation of its requirements. Clearly compliance with the MCA's procedures and good record keeping are important, but there is little sense that the CQC provides any *substantive* scrutiny of its implementation. This is not intended as a criticism of the CQC, rather to acknowledge the limits of regulatory approaches to enforcement of the Act.

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<sup>622</sup> A recent job advertisement for a CQC compliance inspector reflects this shift, requiring experience of 'using analytical information', 'In-depth knowledge of enforcement processes', 'In-depth knowledge of Regulations' under the Health and Social Care Act 2008 and a 'professional demeanour' rather than experience of health and social care itself. (Job description for a 'Compliance Inspector' taken from an advertisement on NHS Jobs (<[www.jobs.nhs.uk](http://www.jobs.nhs.uk)>) with a closing date of 6 March 2012)

A small study of CQC inspection reports for residential care services for people with learning disabilities in Cornwall was conducted to examine how CQC inspectors make reference to issues connected with the MCA. This study is reported in greater detail as Study B2, Appendix B. The study showed that CQC inspectors did make reference to the MCA and various associated concepts, but no topics were routinely covered in reports. Reports contained very few criticisms of practices relating to capacity or consent, and where they did criticisms tended to relate to recording practices rather than the substance of a mental capacity assessment or best interests decision. In two reports inspectors appeared to be under the mistaken impression that where a service user could not offer consent it should be sought from their relative or advocate. Several reports referenced recording practices around restrictions on liberty, but only one questioned the appropriateness of such restrictions.

The DoLS were also most likely to be mentioned in the context of staff training, with only three reports describing whether DoLS authorisation had been, or should have been, sought. Human rights were mentioned in only a handful of reports, and where praise or criticism was offered there was little substantive detail of which rights were being breached or upheld. Compliance inspectors preferred to couch their judgments using less explicitly legal terms like 'person-centred' or 'dignity'. The EHRC (2011a: 87) has argued that CQC should 'use explicit human rights language' to emphasise that 'human rights are enforceable under the HRA rather than being merely aspirational'. There was, however, evidence that compliance inspectors were interested in 'low level' issues such as the quality of a person's surroundings, their diet, their everyday activities and institutional regimes.

### WHOSE VOICE GETS HEARD?

Because the MCA and many human rights values are fundamentally oriented towards a person's will and preferences, actually talking to service users is vital for understanding whether they are being applied appropriately. For example, whether or not a person is objecting to living in a service may be vital to understanding whether or not they are deprived of their liberty.<sup>623</sup> Blanket rules imposed by staff might only be identified by talking to care service users. Hidden abuses would be unlikely to be detected by chatting to staff and residents in public areas. This is no doubt why the MHAC regarded visiting and meeting with patients in private as 'the most effective safeguard' (Mental Health Act Commission, 2009b: [1.3]). The MHAC visitation role also checks whether service users are appraised of ways to take steps to protect their

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<sup>623</sup> However, see discussion of uncertainties regarding the meaning of 'deprivation of liberty' in the context of social care in Chapter 6.

rights themselves, for example through appealing against detention and accessing statutory advocacy services. Consequently, the MHAC methodology is a good example of how visitation can be help to strengthen other safeguards.

CQC has a statutory obligation to publish a statement on how it will involve service users, including ensuring 'that proper regard is had to the views expressed by service users and carers' and making arrangements for its functions to be 'exercised by, or with the assistance of, service users and carers'.<sup>624</sup> The current statement describes a range of strategies, including consulting with service users, involving stakeholder panels, and using 'experts by experience'<sup>625</sup> (Care Quality Commission, 2009b). However, speaking with service users in private is not a required part of the ordinary compliance inspection methodology and is not discussed in the current statement on user involvement.<sup>626</sup>

Asking the right questions is also important. In the post-Winterbourne View national inspection program, CQC visited a care home operated by the same provider, Castlebeck. In March 2011 they had reported 'The service is trying to be person centred', that documentation showed the service promoted 'the independence of the person in their daily lives' and concluded 'the home have a really clear idea of the right sort of care and support to give to the residents' (Care Quality Commission, 2011l). However, an inspection only a few months later heard evidence from residents themselves that the home operated a highly institutional regime, requiring residents to get up, eat, wash, tidy their rooms at particular times, and using punishments and incentives such as banning community access and rationing treats and cigarettes (Care Quality Commission, 2011k). A services' idea of itself as 'person-centred' can only be properly tested by examining the experiences of the people it serves, regardless of how 'person centred' the paperwork appears to be.

CQC include a section on 'what people say about this service' in each of their reports. However, a small audit of CQC reports of compliant and non-compliant residential care services for adults with learning disabilities suggested that quite often inspectors did not speak to users of those services.<sup>627</sup> Several inspectors attributed this to the 'disability' of service users, without comment on whether their own

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<sup>624</sup> s5 Health and Social Care Act 2008

<sup>625</sup> Experts by experience are people who are, or have been, users of services themselves, or are carers of others who are. They accompany CQC compliance inspectors during visits to services. They contributed towards the large inspection program for services for adults with learning disabilities conducted by CQC in the wake of Winterbourne View (Care Quality Commission, 2011b; 2012b). However, there were no signs of use of experts by experience in any of the inspection reports audited for this research (see Studies B2 and B3 in Appendix B). In 2011/12, 506 site visits included experts by experience (Care Quality Commission, 2012a: 24); this amounts to 3% of all site visits by CQC to nursing homes, residential care, domiciliary care and acute services in 2011-12 (see FOI #7).

<sup>626</sup> A new statement of service user involvement is currently being prepared by CQC, however.

<sup>627</sup> See Study B4, Appendix B

knowledge and experience of alternative communication methods may have contributed to their inability to consult with them. In some cases, inspectors sought out the views of relatives or advocates instead, but it was unclear how they had been selected for consultation, and whether they had been chosen by the service itself. In several reports, inspectors merely left the section on 'what people say about this service' blank without further comment as to why service users had not been consulted.

Given the weight that is accorded to the voice of the service management and staff through self-assessment and through guiding inspectors during site visits, it is troubling that seeking out the voice of service users might not be regarded as an absolute priority of inspectors. This is vital information if compliance inspections are to identify violations of people's rights in care services and address matters of concern to service users themselves. If CQC is unable to draw from the voices of service users in their reports, they risk becoming little more than brochures for the 'virtual service' the providers would like to think they are operating.

#### 5.5.4 ENFORCEMENT

In contrast with its predecessors the HCC and CSCI, the CQC has stronger powers of enforcement for compliance. However, examination of data provided under the FOIA by CQC reveals that it uses them only rarely. Between April 2010 – February 2012 CQC issued 518 warning notices, cancelled the registration of 15 providers, imposed conditions of registration of 18 and made one prosecution for regulatory offences (FOIA #9).<sup>628</sup> This might be interpreted as indicative of high levels of compliance in the services it regulates, but this seems unlikely when one considers that its recent audit of learning disabilities services found that only 22% of services were compliant with both Outcome 2 (Consent to care and treatment) and Outcome 4 (Care and welfare of people who use services). Instead it seems likely that CQC adopts a fairly high threshold for formal enforcement action on the basis that services will take action to improve once non-compliance has been brought to their attention.

In contrast with its predecessor commissions, CQC's approach to enforcement was, as its first chair Baroness Young put it, to 'talk softly and carry a big stick' (Carvel, 2008). This signified a change of language used in reports, toning down 'inflammatory' or 'emotive' language and using the 'factual' language of compliance with standards. The reason given for this was the risk that a 'publicly damning report' could damage the ability of provider to improve if nobody would apply for a job with it (Mid-Staffordshire

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<sup>628</sup> On 8 August 2012 CQC had 26,379 registered 'locations' that were nursing homes, residential homes, domiciliary care agencies or acute services (FOIA #7). See Study 4, Appendix B for a more detailed breakdown of the data.

NHS Foundation Trust Public Inquiry, 2012: [34]). In evidence to the Mid Staffordshire Public Inquiry, several CQC whistleblowers argued that the ‘tough’ language of its predecessors played a very important role in promoting compliance (Mid-Staffordshire NHS Foundation Trust Public Inquiry, 2012). Mencap and the Challenging Behaviour Foundation (2012a: 12) have argued that whilst CQC’s inspections may be more rigorous than predecessors, they are:

...not helped by the bland words used in its reports, such as ‘non-compliance’ and ‘failing to meet essential standards’, which betray the seriousness of what this could mean. Hidden behind these words are stories of abuse, neglect and appalling care – of loved family members whose lives have been irrevocably damaged.

From a practical perspective, whether or not language is ‘tough’ or ‘inflammatory’, it must be sufficiently detailed that providers and users of services can understand what a finding of non-compliance means and looks like, in order to be aware of what standards are expected. In their new approach, CQC’s descriptions of what a non-compliant service looks like are markedly less detailed. For example, their post-Winterbourne audit of learning disabilities services used mainly statistical descriptions of regulatory compliance yet contained little of the qualitative detail of the predecessor reports for *A Life Like No Other* (Care Quality Commission, 2012b; Healthcare Commission, 2007b). More recently CQC has commissioned a piece of research looking in more detail at the most recent reports on learning disabilities services, and they have found many of the same restrictive practices and concerns about restraint as those earlier studies (Care Quality Commission, 2012f).<sup>629</sup> Although it might be noted that finding the same problems all over again is hardly indicative that the previous regulators’ descriptive, and perhaps sometimes inflammatory, approach failed to address the problem, it does at least help bring the problem itself into view.

### 5.5.5 IS THE CQC AN EFFECTIVE ENFORCER OF THE MENTAL CAPACITY ACT?

The CQC undoubtedly plays a potentially very important role in enforcing the MCA. Of the four mechanisms for enforcement reviewed in this chapter, it is the only one that is not wholly dependent upon either the person who is alleged to lack mental capacity, a decision maker or a concerned third party involved in their care initiating action. Of the four mechanisms reviewed in this chapter, it is the only one which has displayed a serious interest in tackling the ‘low level’ yet serious interferences adults with learning disabilities experience in care institutions in their everyday lives.

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<sup>629</sup> This research is due to be published alongside recommendations for improvement in 2013.

Furthermore, it is the most transparent of all the above discussed mechanisms,<sup>630</sup> and is very effective at publicising its concerns – including its concerns about restrictive practices in care settings. It can potentially play a very important role in highlighting violations of the MCA in individual cases, and areas of broader public concern.

Nevertheless, I have argued that regulation cannot address all the issues connected with institutional domination, nor enforce all the elements of the MCA. In practice, CQC has an increasingly limited presence ‘on the ground’ in care services as a result of the dramatic decline in inspection levels over the last decade. The decision to develop a generic, and not specialised, compliance inspection workforce, means that insofar as the MCA requires specialist communication skills, knowledge of best practice or detailed knowledge of the Act itself, CQC’s ability to enforce the Act will be limited.

Yet even if these obstacles were overcome, there are limits to what issues and concerns inspectors can detect and respond to in the course of a day’s visit. Whereas IMCAs and courts tend to be concerned with how a person ends up in a place or having a particular treatment, CQC is less able to detect and respond to matters which straddle the responsibilities of providers and commissioners of services. Its strength lies in its attention to detail in everyday life, to identifying - for example - that service users are required by providers to ask before making a cup of tea, or to get up earlier than they would like to. These are, as has been repeatedly stressed throughout this thesis, important issues which have a significant impact upon people’s wellbeing and personal development. Nevertheless, they are not the whole story, and very often they will interlock with assessment and commissioning decisions which typically lie outside CQC’s remit.

## 5.6 DISCUSSION: ENFORCEMENT MECHANISMS FOR THE MENTAL CAPACITY ACT

The foregoing discussion describes a patchwork of potential mechanisms of enforcement for the MCA, each with particular ‘trigger’ mechanisms, methods of inquiry and enforcement, and each tending to attend to different types of issues. It might be thought that with such a range of alternatives for enforcement, adults with learning disabilities are well protected against arbitrary departures from the requirements of the MCA. Yet each mechanism had significant shortcomings for this purpose when one

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<sup>630</sup> Almost all of CQC’s reports are available online, as are minutes of its board meetings and a wealth of other information about how it functions. I have also found it to be by far and away the most ‘transparent’ organisation I have requested information on using the FOIA. By contrast, only a small proportion of Court of Protection judgments and LGO reports are ever published, there is limited available information about their internal policies and practices and limited statistical data giving an overview of their work. Similarly, there is only limited information in the public domain about the work of IMCAs, and we know very little indeed about outcomes from their work.

delves into their practical application and design. In essence, the mechanisms for guarding against arbitrary interferences can themselves be highly arbitrary in their application. An arbitrary enforcement mechanism cannot be a good remedy for states of domination. There are too many ways in which its application can be avoided by the ignorant or unscrupulous, and people who are subject to dominating power relations will not experience the security of knowing they are effectively protected against arbitrary interferences by third parties.

A central difficulty with relying upon complaints procedures and the Court of Protection is their reliance upon the person whose rights have been interfered with being able to identify this, and take the appropriate action. A variety of reasons for believing adults with learning disabilities in institutional care will struggle to do so have been reviewed here. Advocacy could overcome many of these difficulties, but the form of advocacy provided for by the MCA itself suffers from a number of serious deficiencies. In particular, it is only available for a small subset of decisions made under the MCA, the duties of advocates to assist people in challenging decisions made under the MCA are not clearly defined, and all the evidences suggests that advocates very rarely do so.

Even if a person is able to initiate a challenge via a complaints mechanism or in the Court of Protection, there are difficulties with using either channel as a means to 'appeal' against interferences founded on a person's incapacity. There is no evidence to suggest that the LGO would independently assess the mental capacity of a complainant, and they would have no powers to issue a declaration of a person's mental capacity or best interests. The Court of Protection has the requisite powers, but the number of cases reaching the court is extremely low, suggesting it is not an accessible mechanism for the vast majority of MCA related disputes. Furthermore, if a person is represented through a litigation friend, evidence of mental incapacity may not be fully adversarially tested in court, meaning that the courts are excessively reliant upon professional judgment. By court and LGO alike, expert opinion on mental incapacity may generally be accepted uncritically, and so these mechanisms are poorly placed to constrain any arbitrariness which creeps into mental capacity assessments.

The CQC overcomes the difficulties of access to justice, but their presence is increasingly thin on the ground and it is questionable whether their inspectors have the requisite time or expertise to pick up on complex problems with implementing the MCA. Furthermore, the CQC cannot address issues which are related to the decisions of commissioners. The CQC do not offer any kind of a review of an assessment of incapacity or best interests decisions; like the LGO, they are only equipped to pick up on defects in procedure and recording for decisions relating to the MCA.

Contrasting the content of the Act with the means of enforcing it reveals its paradoxical stance towards disability and the rule of law. On the one hand, the MCA recognises (perhaps perpetuates) the depleted autonomy of people with mental disabilities. On the other hand, the processes and procedures of the court are oriented towards the 'ontologically autonomous, self-sufficient, unencumbered subject' (Brown, W., 2002: 431; Scott, 1996) of liberal mythology. It is a central principle of republicanism and the rule of law that law must be accessible to those affected by it. Yet the MCA has done little to help people with mental disabilities to access justice in order to fend off arbitrary interferences with their rights. IMCAs and litigation friends play an ambivalent role in this process. On the one hand they potentially assist a person to participate in decisions and legal challenges which affect them. On the other hand, they serve to filter out the irrational, unpredictable and slow from professional decisions and courtrooms, to optimise the efficiency and propriety with which their affairs can be despatched. In so doing, central ideas of justice and the rule of law – of transparency, equality of arms, of adversarial testing of disputes – become distorted.

Given the serious difficulties people with mental disabilities will experience in using the Court of Protection to 'appeal' against interferences with their choices and freedoms, it is small wonder these issues make very few appearances in the case law reviewed in Chapter 3. The claims of Rose (1985) and Brown (2002), that differential access to justice can skew legal systems towards the interests of the powerful, and entrench unequal power relations seem well founded here. In effect, the primary use made of the Court of Protection appears to be to mediating conflicts between two possible groups of substituted decision makers: professionals (mainly health and social care), and family and social networks. If people with mental disabilities dispute a decision made under the MCA that affects them, they are likely to be unsuccessful in resisting it unless somewhere in one of those groups is a person who seeks the same outcome as them, and is willing and able to fight for it.

These difficulties with the enforcement of the MCA in institutional settings suggest that the degree to which the MCA may provide a 'promising lever' (Care Quality Commission, 2012f: 12) for tackling the arbitrary restrictions connected with institutional care will be limited. No other independent mechanism than the court has the power to prevent admission or help a person leave a service where they are unhappy, make a declaration that a person has mental capacity, nor make personalised but enforceable recommendations for the lifting of restrictions. Yet the court, for most, will be beyond reach. One last mechanism of enforcement which will be considered in this thesis is potentially able to unpick the relationship between these kinds of day to day restrictions with larger questions of how a person ended up subject to them in the first place. It may overcome many of the difficulties people with learning



disabilities face in asserting their rights through legal channels. That mechanism is the DoLS, and it is to this widely derided yet also perhaps promising framework that I now turn.



# CHAPTER 6 – THE DEPRIVATION OF LIBERTY SAFEGUARDS

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## 6.1 INTRODUCTION

By the time the MCA was passed by parliament, it was known that it would need to be amended to take into account the decision of the European Court of Human Rights (ECtHR) in *HL v. United Kingdom*<sup>631</sup> (Department of Health, 2005a; Joint Committee on Draft Mental Incapacity Bill, 2002-3: [223]-[225]). The case concerned the ‘informal’ hospital admission of HL, a man with autism who lived in the community with his carers, Mr and Mrs E. HL had displayed agitated behaviour at his day centre and, unable to cope, the day centre called his GP and a social worker who decided to take him to Bournemouth Hospital. HL had in fact previously lived in Bournemouth Hospital for 31 years before moving in with Mr and Mrs E under an ‘adult placement’ scheme<sup>632</sup> (Health Service Ombudsman, 2001; Robbins, 2008).

At Bournemouth Hospital, HL was reported not to resist or ‘object’ to his admission, nor to try to escape.<sup>633</sup> However, HL was heavily sedated at the time he was admitted<sup>634</sup> and he had impairments which limited his ability to communication.<sup>635</sup> The hospital refused to let Mr and Mrs E visit HL for the first four months of his detention in case he tried to leave with them,<sup>636</sup> and refused requests to discharge him into their care.<sup>637</sup> Because HL was not detained under the MHA, he and his family could not use the mechanisms therein to seek his discharge.<sup>638</sup> HL’s cousin, acting as his litigation friend, applied to the court for judicial review of the decision to admit HL to hospital, sought a writ of habeas corpus and damages for false imprisonment and assault connected with the admission.<sup>639</sup> The Court of Appeal found that HL had been falsely imprisoned, and that the hospital should have used the MHA to admit him formally.<sup>640</sup>

The Court of Appeal’s decision caused consternation amongst health authorities and care providers. The Secretary of State for Health, the Mental Health Act

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<sup>631</sup> (App no 45508/990) [2004] 40 EHRR 761

<sup>632</sup> These are now called ‘Shared Lives’ schemes, and involve a person moving in with paid carers in their own home, either on temporary or long-term basis.

<sup>633</sup> *HL v UK*, [12]

<sup>634</sup> *HL v UK*, [46]

<sup>635</sup> *HL v UK*, [120]

<sup>636</sup> *HL v UK*, [13], [18]

<sup>637</sup> *HL v UK*, [23]

<sup>638</sup> A person may not be detained under s2 or s3 MHA if a person’s ‘nearest relative’ objects, and the nearest relative may discharge a person. The detainee themselves may apply to a tribunal to be discharged.

<sup>639</sup> *HL v UK*, [31]

<sup>640</sup> *R. v Bournemouth Community and Mental Health NHS Trust Ex p. L* [1997] EWCA Civ 2879

Commission (MHAC) and the Registered Nursing Homes Association all intervened in *R v Bournemouth Community and Mental Health NHS Trust Ex p. L*<sup>641</sup> in the House of Lords and relayed the considerable resource implications of the Court of Appeal's ruling. It was estimated that it might mean an additional 22,000 formally detained residents on any given day, whereas the current figure was said to be between 11-13,000. The MHAC raised further concerns that some patients might be detained in nursing homes, which were not registered for detention under the MHA. Professional bodies and charitable organisations were reported to be concerned about the impact on patients and their carers of being detained under the MHA. In the context of this groundswell of opposition to bringing compliant but incapacitated patients within the scope of the MHA, a majority in the House of Lords found that HL had not, in fact, been 'falsely imprisoned', and that in the event that he had been this would have been justified under the common law doctrine of necessity. Lord Goff distinguished between 'restraint upon the plaintiff's liberty which is conditional upon his seeking to exercise his freedom (which would not amount to false imprisonment), and an actual restraint upon his liberty'.

Lord Steyn issued a powerful dissent to the majority finding that HL was not detained, commenting 'The suggestion that "L" was free to go is a fairy tale.' He noted that the 'unfortunate effect' of the judgment was 'to leave compliant incapacitated patients without the safeguards enshrined in the [MHA 1983]'. In the meantime, HL himself had been detained under the MHA following the Court of Appeal's ruling, and had been discharged after an independent expert found that he did not meet the criteria for detention under the Act.<sup>642</sup>

Following his ordeal, HL's case that he had been unlawfully detained was pursued to the ECtHR. The Strasbourg court rejected the House of Lords' distinction between 'actual restraint' and 'restraint which was conditional upon his seeking to leave'<sup>643</sup> and found that HL had been deprived of his liberty within the meaning of Article 5 ECHR. The ECtHR found that the common law doctrine of necessity did not satisfy the 'aim of avoiding arbitrariness'.<sup>644</sup> The ECtHR was struck by 'the lack of any fixed procedural rules by which the admission and detention of compliant incapacitated persons is conducted', and contrasted 'this dearth of regulation' with 'the extensive network of safeguards applicable to psychiatric committals covered by the [MHA 1983]'.<sup>645</sup> The Strasbourg Court's complaint was, in spirit, a republican one: that the common law failed to supply clear principles for the detention of incapacitated but

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<sup>641</sup> [1998] UKHL 24. No paragraph numbers are available for this judgment.

<sup>642</sup> *HL v UK*, [17]-[22]

<sup>643</sup> *HL v UK*, [90]

<sup>644</sup> *HL v UK*, [119]

<sup>645</sup> *HL v UK*, [120]

compliant adults, and the mechanisms available to a person to ‘invigilate’ any such interferences were inadequate. Like republicans, the court was not concerned with whether or not the interference was well intentioned in the particular case:

While the Court does not question the good faith of those professionals or that they acted in what they considered to be the applicant’s best interests, the very purpose of procedural safeguards is to protect individuals against any “misjudgments and professional lapses”.<sup>646</sup>

The lack of procedural safeguards for the deprivation of liberty of incapacitated adults became known as the ‘Bournewood gap’, and the deprivation of liberty safeguards (DoLS) were developed to attempt to plug it.

### 6.1.1 THE BOURNEWOOD CONSULTATION AND THE DEVELOPMENT OF THE DEPRIVATION OF LIBERTY SAFEGUARDS

Following the ruling in *HL v UK*, the Department of Health (2005a; 2006d) consulted on the introduction of legal safeguards to bring England and Wales into compliance with Article 5. The *Bournewood Consultation* proposed ‘a new system to govern admission/detention procedures, reviews of detention and appeals’ entitled ‘Protective Care’ (Department of Health, 2005a: [5.2]). In November 2006 the government introduced a draft Mental Health Bill, which contained the amendments to the MCA that were to become the deprivation of liberty safeguards.<sup>647</sup> Hargreaves (2009: 118) records that ‘At the time of the first stakeholder consultation meeting in September 2006 the scheme appeared to be still in a very raw and unsatisfactory state, with much unnecessary complexity’, but the Schedules had already been ‘signed off’ and could be amended only in detail. According to Hargreaves, efforts to ‘compensate for the deficiencies in the Schedules’ resulted in inconsistencies between the Schedules and the code of practice, meanwhile parliament and civil society groups were preoccupied by other matters connected with the Mental Health Bill (p118).<sup>648</sup> Jones, R., (2012: v) writes

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<sup>646</sup> *HL v UK*, [121]. The ECtHR endorsed Lord Steyn’s comments that the decision in Bournewood ‘...places effective and unqualified control in the hands of the hospital psychiatrist and other health care professionals. It is, of course, true that such professionals owe a duty of care to patients and that they will almost invariably act in what they consider to be the best interests of the patient. But neither habeas corpus nor judicial review are sufficient safeguards against misjudgments and professional lapses in the case of compliant incapacitated patients.’

<sup>647</sup> The bill was introduced to Parliament on 16 November 2006; the draft bill is available here: <<http://www.publications.parliament.uk/pa/ld200607/ldbills/001/2007001.pdf>> [accessed 14 November 2012]

<sup>648</sup> Hargreaves cites debates around Community Treatment Orders and the ‘appropriate treatment’ test as particular objects of focus to professional and civil society groups at the time.

that 'It is surely scandalous that the [schedules] ...did not give rise to one word of debate during the Bill's passage through both Houses of Parliament.'<sup>649</sup>

The Joint Committee on Human Rights (2006-07: [1.26]-[1.29]; 2007b: [89]-[90]) raised concerns about the complexity of the scheme and endorsed JUSTICE's<sup>650</sup> call for a statutory definition that would clearly define who needed safeguards, instead of relying on the courts to define 'deprivation of liberty'. A large number of responses to the Bournewood Consultation (FOIA #21; Department of Health, 2005a; 2006d), the consultations on the DoLS code of practice (FOIA #22, #25; Ministry of Justice and Department of Health, 2007a; b; c), and the consultations on monitoring and reporting on the DoLS (FOIA #23; Department of Health, 2008b; 2009a), expressed similar concerns and raised other serious problems.<sup>651</sup> However, the schedules 'passed into law unscrutinised and unamended' despite these widely voiced concerns (Hargreaves, 2009: 119).

During the consultations (Ministry of Justice, 2008; Ministry of Justice and Department of Health, 2007a; b; c; 2008a), it was never quite clear what problem the DoLS were attempting to fix, beyond insulating the UK from further litigation like *HL v UK*. Estimates of the number of people who might need safeguards diverged widely, suggesting differing conceptions of what 'deprivation of liberty' might mean. The Bournewood Consultation put the figure at 98,000 (Department of Health, 2005a: [3.1]-[3.6]), meanwhile the impact assessment put the figure at 21,000 (Ministry of Justice and Department of Health, 2008a).<sup>652</sup> Most respondents to the consultation felt the impact assessment underestimated the number of people affected (Ministry of Justice and Department of Health, 2008b: 15), but the government (Ministry of Justice and Department of Health, 2008a: [16]) did not accept:

...the view expressed by some respondents to the consultation that every person who lacks capacity to consent to the arrangements made for their care or treatment, and who is in a care home from which they are not

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<sup>649</sup> In fact, there are records of debates in the House of Lords about DoLS. Particular concern was expressed around the lack of certainty of the number of people who would need the safeguards and the likelihood that, in light of *JE v DE & Ors* [2006] EWHC 3459 (Fam), the government had underestimated this number. See: *Hansard* HL vol 455 col 98 (29 January 2007); *Hansard* HL vol 455 col 727 (17 January 2007); *Hansard* HL vol 457 col 1485 (27 February 2007); *Hansard* HC Vol 525 Col 140WH (17 March 2011); *Hansard* HL vol 460 col 392-6 (15 May 2007) and *Hansard* HL vol 460 col 390 (16 May 2007).

<sup>650</sup> JUSTICE are an NGO who 'promote access to justice, human rights and the rule of law – through research, education, lobbying and interventions in the courts.' The briefing by JUSTICE can be found here:

<[http://www.justice.org.uk/data/files/resources/153/Mental\\_Health\\_Act\\_HL2ndreading\\_JUSTICE\\_briefing\\_nov06.pdf](http://www.justice.org.uk/data/files/resources/153/Mental_Health_Act_HL2ndreading_JUSTICE_briefing_nov06.pdf)> [accessed 14 November 2012]

<sup>651</sup> See also Robinson (2007) for similar criticisms.

<sup>652</sup> It was even suggested in Parliament that it might be as many as 400,000 *Hansard* HL vol 455 col 98 (29 January 2007).

allowed complete freedom of egress, are inevitably deprived of their liberty within the meaning of Article 5 of the ECHR.

The impact assessment suggested that *Bournewood* was an ‘extreme’ circumstance.<sup>653</sup> Guidance from the early draft DoLS code of practice advised commissioners and care providers that they could avoid deprivation of liberty by maximising people’s day to day choices and apply the principles of person-centred planning (Ministry of Justice and Department of Health, 2007c: [2.12]-[2.25]). However this guidance, which seemed to identify deprivation of liberty with a loss of freedom *within* an institution, was excised from the final DoLS code of practice (Ministry of Justice, 2008).

Hitching safeguards to a definition of ‘deprivation of liberty’ to be supplied by the courts has proven to be one of the most fundamental and enduring problems with the DoLS, although it was a difficulty widely foreseen during the consultations (Department of Health, 2005a; 2006d; Ministry of Justice and Department of Health, 2007a; b).<sup>654</sup> The definition(s) supplied by the courts proved to be complex, controversial and sometimes contradictory, and will be discussed in more detail below. Two of the most recent and defining rulings from the Court of Appeal on the meaning of deprivation of liberty, *P & Q v Surrey County Council* and *Cheshire West and Chester Council v P*, have generated considerable debate, and have been granted permission to appeal to the Supreme Court in October 2013. Meanwhile in 2012 the ECtHR issued a trinity of rulings which found, for the first time, that a person could be deprived of their liberty in a social care facility. The rulings in *Stanev v Bulgaria*, *D.D. v Lithuania* and *Kędzior v Poland* applied criteria which differed significantly from the approach taken by the domestic courts, and it has been suggested that they may mean that the domestic authorities will need to be reconsidered (Ruck Keene et al., 2012e: 23-4; Lord Justice Munby, 2012c).

The complexity of the Schedules themselves has given considerable cause for concern. Barrister Paul Bowen QC, who represented HL in *Bournewood*, has commented that the provisions are ‘so labyrinthine and bureaucratic that those responsible for administering them are likely to take every opportunity to avoid using them’ (Bowen, 2007: ix).<sup>655</sup> Professor Richard Jones (2010: v) has described the DoLS as ‘complex, voluminous, overly bureaucratic and difficult to understand’ whilst providing

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<sup>653</sup> [24]

<sup>654</sup> Angela Browning MP pressed Rosie Winterton MP, the minister responsible for the Bill, several times about her concerns that deprivation of liberty was not sufficiently clearly defined and that lawyers were concerned that the government had significantly underestimated the numbers of people whom might need safeguards. *Hansard* HL vol 460 col 392-6 (15 May 2007)

<sup>655</sup> A recent study by Varghese et al (2012: Figure 2) found that around 90% of psychiatrists surveyed felt the DoLS were causing unnecessary bureaucracy.

‘mentally incapacitated people with minimum safeguards’. The Mental Health Alliance has written several critical reports about the DoLS and recently described them as ‘not fit for purpose’ (Hargreaves, 2010; 2011; Mental Health Alliance, 2012). Several authors have raised concerns about conflicts of interest in the operation of the safeguards (Bowen, 2007; Scott-Moncrieff, 2007). Richard Jones (2007; 2010; 2012) and the Mental Health Lawyers Association (2011) have continued to argue that a simpler and cheaper alternative to DoLS would be to replace it with an amended form of guardianship under the MHA.<sup>656</sup>

The scheme even appears unpopular amongst the judiciary. Lady Hale echoed Paul Bowen’s description of the DoLS as ‘decidedly inelegant’ (Hale, 2009b: 114), Munby LJ has called them ‘labyrinthine’ (Lord Justice Munby, 2012a: 33) and Jackson J recently issued the following *cri de coeur* in *C v Blackburn and Darwen Borough Council*<sup>657</sup>:

It is a truly unhappy state of affairs that the law governing the fundamental rights and welfare of incapacitated people should be so complex. As this case shows, its intricacies challenge the understanding of professionals working in the field and are completely inaccessible to those for whose benefit the legislation has been devised, including those with a relatively high level of understanding, such as Mr C.<sup>658</sup>

As the JCHR (2007b: [90]) noted, the DoLS scheme may so complex that it does not satisfy the basic requirement of the rule of law, that it is ‘adequately accessible: the citizen must be able to have an indication that is adequate in the circumstances of the legal rules applicable to a given case.’<sup>659</sup>

This complexity does not merely mean that those using the scheme must work harder to understand it. As Bowen notes, it increases the likelihood that those who are supposed to apply the safeguards will avoid using them where possible. The complexity and indeterminacy of the schedules and regulations increase the number of conflicts that arise, some of which require extraordinarily complex and lengthy judicial interpretations. It also increases the likelihood of mistakes being made by those applying the schedules, and in many cases it is genuinely difficult to determine the correct course of action from

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<sup>656</sup> Whilst I recognise that guardianship has several advantage over the DoLS scheme, not least that it gives families of detainees greater powers to object to detention, I respectfully disagree with the authors that an amended form of guardianship would be preferable to DoLS. My chief reason for holding this view is that the criteria for entry into the DoLS are much more satisfactory than guardianship, and the Court of Protection’s more expansive powers under s21A MCA are better equipped for addressing the issues which arise under DoLS than the powers of tribunals under the MHA. I have explained my reasoning at greater length elsewhere (Series, 2012c).

<sup>657</sup> [2011] EWHC 3321 (COP)

<sup>658</sup> *C v Blackburn and Darwen Borough Council*, [24]

<sup>659</sup> *The Sunday Times v United Kingdom*, [49]



the schedules and the case law.<sup>660</sup> As Jackson J noted, the rights of those who are detained, and those supporting them, can be extremely difficult to discern.

Small wonder, then, that in two notorious cases which occurred *after* the DoLS scheme came into force it took Mr E in *G v E & Ors* and Steven Neary in *London Borough of Hillingdon v Neary & Anor* longer than HL to successfully challenge their unlawful detentions.<sup>661</sup> The problems with the DoLS scheme are too numerous, and too complex, to cover comprehensively in this chapter. However, the key defining difficulty which prevents the scheme fulfilling its purpose can be simply put: *at every point in the scheme, for every safeguard, those responsible for the confinement and control of disabled adults have too much unconstrained discretion to avoid applying the safeguards in a fashion which would act as a brake against their power.* Nevertheless, even amidst such complexity and such potential for arbitrariness there are signs that for the dogged and persistent amongst detainees, their supporters and professionals, the framework can yield positive results. Whilst the scheme is in no sense adequate to the task of reducing the arbitrariness of interferences in the lives of adults with mental disabilities in institutional care services, it offers several tantalising pointers towards measures which potentially could be.

## 6.2 AN OVERVIEW OF THE DOLS

It is not possible in one chapter to go into detail about the operation of all aspects the Schedules, although excellent introductions are given by Bartlett (2008), Bowen (2007), Hale (2011) and, of course, Jones, R., (2010; 2012). In particular, I have not discussed in any great detail the interaction between the MHA and the DoLS. This is because adults with learning disabilities predominantly live in residential care and supported living services (Mencap, 2011), and make up fewer than 1% of the population detained under the civil provisions of the MHA (NHS Information Centre for Health and Social Care, 2012e).<sup>662</sup> The intersection between the MHA and the MCA/DoLS is extremely complex and worthy of a chapter in its own right (Allen, 2010; Bartlett and McHale, 2003; Cairns et al., 2010; Jones, R., 2007; Morris, F., 2012; Rapaport et al., 2009; Richardson, 2010). To help the reader navigate the various elements of the

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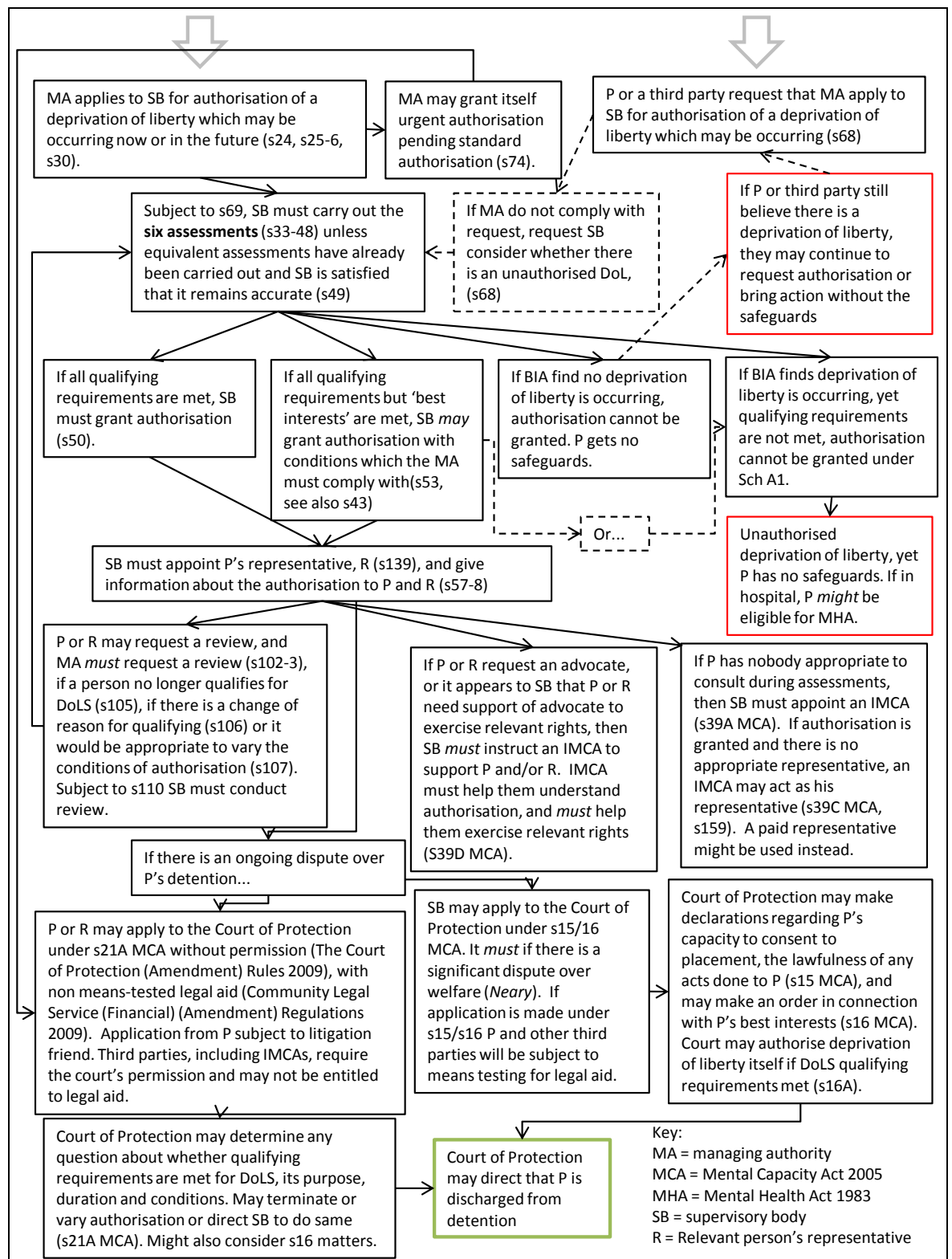
<sup>660</sup> For evidence of this, I recommend reading the archives of the Mental Health Law Online Discussion List, where questions about the correct use of the DoLS are posed and debated on a daily basis, <http://www.mentalhealthlaw.co.uk/Discussion> [accessed 13 January 2013]

<sup>661</sup> HL was unlawfully deprived of his liberty between July and December 1997, just under five months. E was deprived of his liberty between November 2008 and January 2010 – a period of around fourteen months. Steven Neary was deprived of his liberty between January and December 2010, for just under twelve months.

<sup>662</sup> In relation to detention and guardianship under Part II, s1 MHA defines mental disorder in such a way as to preclude people with learning disabilities unless it 'is associated with abnormally aggressive or seriously irresponsible conduct'.

safeguards, this overview is supported by a schematic diagram in Figure 4, which depicts the various decisions, actions and outcomes in the DoLS scheme.

Figure 4 Schematic diagram of the deprivation of liberty safeguards<sup>663</sup>



<sup>663</sup> Unless otherwise stated the section numbers in the flow diagram refer to paragraphs of Schedule A1 MCA

The entry point into the safeguards is for the managing authority of the hospital or care home where 'P' lives to apply to the 'supervisory body' for authorisation for the possible deprivation of liberty of P.<sup>664</sup> For care homes the supervisory body is the local authority,<sup>665</sup> and for hospitals it is currently the Primary Care Trust (PCT).<sup>666</sup> P or a third party may request the supervisory body to decide whether or not there is an unauthorised deprivation of liberty, provided they have already requested that the managing authority make an application and they have not done so within a reasonable period of time.<sup>667</sup> If the possible deprivation of liberty is already occurring, or will occur imminently, the managing authority can grant itself an 'urgent authorisation' for seven days, pending the supervisory body's consideration of its application for a 'standard authorisation'.<sup>668</sup> The supervisory body must conduct six assessments by a minimum of two assessors – including a 'best interests assessor' (BIA) and a mental health assessor – to see if six qualifying requirements are met.<sup>669</sup> The six qualifying requirements are:

1. The age requirement: P must have reached the age of 18.<sup>670</sup>
2. The mental health requirement: P must be suffering from a mental disorder within the meaning of the MHA, but disregarding any exclusion of persons with learning disabilities.<sup>671</sup>
3. The mental capacity requirement: P must lack the mental capacity to decide whether or not he should be accommodated in the relevant hospital or care home for the purpose of being given the relevant care or treatment.<sup>672</sup>
4. The best interests requirement:
  - a. P must be, or be going to be, a detained resident;
  - b. It must be in the best interests of P for him to be a detained resident;
  - c. It must be necessary, in order to prevent harm to P, for him to be a detained resident;

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<sup>664</sup> s24 Sch A1

<sup>665</sup> s182 Sch A1

<sup>666</sup> s181 Sch A1. Although, as of April 2013 local authorities will be supervisory bodies for both hospitals and care homes (Department of Health, 2012a). This is because PCTs are to be abolished and replaced by 'Clinical Commissioning Groups' operated by general practitioners, under the Health and Social Care Act 2012.

<sup>667</sup> s68 Sch A1

<sup>668</sup> s74 Sch A1

<sup>669</sup> s33-48 Sch A1, although the supervisory body is exempt from this requirement if equivalent assessments have already been carried out within the previous 12 months and the supervisory body is satisfied that they remain accurate (s49).

<sup>670</sup> s13 Sch A1; s34 Sch A1

<sup>671</sup> s14 Sch A1

<sup>672</sup> s15 Sch A1

- d. It must be a proportionate response to the likelihood of P suffering harm and the seriousness of that harm for him to be a detained resident.<sup>673</sup>
5. The eligibility requirement: P must be eligible to be deprived of his liberty by the MCA, which is to be determined by reference to Schedule 1A. Schedule 1A specifies which individuals are ineligible to be deprived of their liberty by the MCA because of its relationship with the MHA.<sup>674</sup>
6. The no refusals requirement: P cannot be deprived of his liberty under the DoLS for the purpose of administering treatment which conflicts with a valid advance decision he has made, or where the authorised detention would conflict with the valid decision of a donee of an LPA or a deputy that he should not given a particular treatment or accommodated in the care home or hospital specified in the authorisation.<sup>675</sup>

If the assessors find that each of the six qualifying requirements are met, the supervisory body *must* grant a standard authorisation for the detention;<sup>676</sup> if any of the qualifying requirements are not met then the supervisory body *may not* grant any such authorisation.<sup>677</sup> BIA's may recommend that particular conditions be attached to the authorisation<sup>678</sup> and the supervisory body must have regard to these recommendations when deciding what conditions to impose on managing authorities.<sup>679</sup> The supervisory

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<sup>673</sup> s16 Sch A1

<sup>674</sup> Eligibility is such a complex area in its own right, I have not devoted significant attention to it here. In *GJ v The Foundation Trust & Anor* [2009] EWHC 2972 (Fam), Charles J held that if the MHA could be used to detain a person, then it should be used in preference to the DoLS. In essence, clinicians had no discretion to pick and choose between the MHA and the DoLS in the context of detention for the purpose of medical treatment. Where either detention framework might apply, eligibility for the DoLS is determined first by reference to the 'status test' and the 'objections test'. The status test states that if, 'but for' their physical treatment needs, the person would not be detained, then they are eligible for the DoLS. But a person might still be eligible for DoLS even if they are being detained for the purpose of treatment for mental disorder if their behaviour indicates that they are not objecting. Neil Allen (2010) observes that the broadened definition of 'objections' would have encompassed HL in the Bournemouth case, who was detained for treatment of a mental (not physical) disorder. Consequently, ironically, HL himself would not have been eligible for the DoLS. The eligibility requirement can also potentially bring the DoLS into conflict with decisions made under MHA regimes (e.g. guardianship, s17 leave etc), where those decisions would result in a deprivation of liberty which can only be authorised under the MCA, but where the DoLS requirements are not met. In such cases, it is unclear how to proceed – nothing under the MHA can authorise that detention, but no decision of the Court of Protection can 'trump' the MHA regime. See: *C v Blackburn and Darwen Borough Council*.

<sup>675</sup> s18 Sch A1

<sup>676</sup> s50 Sch A1

<sup>677</sup> s22 Sch A1

<sup>678</sup> s43 Sch A1

<sup>679</sup> s53 Sch A1

body may grant a standard authorisation for a period of time which does not exceed the duration recommended by the BIA<sup>680</sup> or one year, whichever is the shorter.<sup>681</sup>

Once a standard authorisation has been granted, the supervisory body must appoint someone to act as P's representative (R).<sup>682</sup> Regulations specify that R must be chosen by P if the BIA assesses him as having the mental capacity to do so, otherwise R must be chosen by any donee of an LPA or deputy if it is within the scope of their authority. In the alternative, R must be selected by the BIA herself.<sup>683</sup> If the BIA feels there is no suitable person to act as P's representative, they may either pay a person to act as R (a 'paid representative')<sup>684</sup> or instruct an IMCA under s39C MCA. A paid representative or a s39C IMCA generally has the same rights under the schedules as any other R. Rs have various rights for their views to be considered by BIAs conducting assessments<sup>685</sup> and to be kept informed regarding any assessments or reviews.<sup>686</sup> R's have rights to request Part 8 reviews of standard authorisations<sup>687</sup> and special rights connected with 'appeals' against the detention under s21A MCA, discussed below. The managing authority is responsible for monitoring R and reporting to the supervisory body on the extent to which he maintains contact with P.<sup>688</sup>

Once a standard authorisation is granted the supervisory body may conduct a review at any time to ensure the qualifying requirements are still met, and it must do so if such a request is made by P, P's representative<sup>689</sup> or the managing authority of the hospital or care home.<sup>690</sup> The grounds for a review are that P does not meet the qualifying requirements<sup>691</sup> the reason why the person meets any of those requirements has changed,<sup>692</sup> or that a person's situation has changed and hence it might be

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<sup>680</sup> s42 Sch A1

<sup>681</sup> s51 Sch A1

<sup>682</sup> s139 Sch A1

<sup>683</sup> The Mental Capacity (Deprivation of Liberty: Appointment of Relevant Person's Representative) Regulations 2008

<sup>684</sup> NB: these would be subject to various 'conflict of interest' rules in the Mental Capacity (Deprivation of Liberty: Appointment of Relevant Person's Representative) Regulations 2008

<sup>685</sup> s49 and s132 Sch A1

<sup>686</sup> Informed: To receive a copy of the authorisation: s57 Sch A1; To receive copies of any written information given to P by the managing authority to explain the standard authorisation to them: s59 Sch A1; To be informed if a standard authorisation has ceased to be in force: s65 Sch A1, or has been suspended: s93 Sch A1, or ceased to be suspended: s95 Sch A1; To be notified of any pending Part 8 Review: s108 Sch A1, and the outcome of any such reviews: s120 Sch A1, and to be given written records relating to any requests for reviews and their outcomes: s121 Sch A1; To receive written records of any assessments conducted for the DoLS: s135 Sch A1.

<sup>687</sup> s102 Sch A1

<sup>688</sup> s147 Sch A1

<sup>689</sup> The role of P's representative will be discussed shortly.

<sup>690</sup> s101 Sch A1

<sup>691</sup> s105 Sch A1

<sup>692</sup> s106 Sch A1

appropriate to vary the conditions the authorisation is subject to.<sup>693</sup> A review may not be carried out on any other grounds,<sup>694</sup> and the supervisory body is not required to take any action if no qualifying requirements ‘appear to be reviewable’.<sup>695</sup> If it appears to the managing authority that one or more of these grounds for review are met, then they must request a review.<sup>696</sup> The supervisory body must conduct assessments for the purpose of reviewing the relevant aspects of the authorisation,<sup>697</sup> and if one or more of these review assessments comes to a negative conclusion the supervisory body must terminate the standard authorisation with immediate effect.<sup>698</sup> This procedure is sometimes known as a ‘Part 8 Review’ as it is described in Part 8 of Schedule A1.

Once an urgent or standard authorisation has been granted, any person – including P, P’s representative or any other concerned third parties – may apply to the Court of Protection under s21A MCA to ask the court to determine any of the following matters:

- whether the relevant person meets one or more of the qualifying requirements;
- the period during which the authorisation is to be in force;
- the purpose for which the authorisation is given;
- the conditions subject to which the authorisation is given.

Having determined any of these matters, the court may make an order varying or terminating the authorisation, or directing the supervisory body to do so. Consequently, s21A MCA is sometimes referred to as the ‘appeal’ mechanism under the DoLS, although it is nowhere referred to as such in the statute or its schedules. Section 21A MCA represents the means by which P is ‘entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful’, in accordance with Article 5(4). Unlike appeals against detention under the MHA,<sup>699</sup> however, there is no automatic periodic review of detention under the DoLS by a court. Although any person may apply to the Court of Protection under s21A MCA, the usual requirement that the court’s permission to initiate proceedings is sought first applies for any claimant other than P, P’s representative<sup>700</sup> or

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<sup>693</sup> s107 Sch A1

<sup>694</sup> s104 Sch A1

<sup>695</sup> s110 Sch A1

<sup>696</sup> s103(2) Sch A1

<sup>697</sup> ss112-116 Sch A1

<sup>698</sup> s117 Sch A1

<sup>699</sup> Under s68 MHA hospital managers have a duty to refer a patient’s case to a tribunal if they have been subject to Part 2 or Part 4A MHA (other than guardianship) for a period of six months without having exercised that appeal right.

<sup>700</sup> Under The Court of Protection (Amendment) Rules 2009 SI 2009/582, rule 6 (definitions) of the Court of Protection Rules was amended so that ‘P’ included the ‘relevant person’ in Schedule A1,

any other parties generally exempt from seeking permission.<sup>701</sup> Both P and P's representative are entitled to non means-tested legal aid,<sup>702</sup> although public funding is still subject to a 'merits' test.<sup>703</sup> Consequently, for P and R at least, being subject to a DoLS authorisation removes two significant access to justice hurdles in seeking a review by the Court of Protection: permission to bring proceedings, and funding for litigation.

Where P has an unpaid representative, he and R have a right to support from an IMCA under s39D MCA. Under s39D the IMCA must take such steps as are practicable to help P and R understand the effect, purpose and duration of the authorisation, any conditions of authorisation, and why assessors decided that P met the qualifying requirements for the authorisation. S39D IMCAs must also help P and R understand their rights and how to exercise them, and they must 'take such steps as are practicable' to help P or R exercise their right to apply to court or their right of review 'if it appears to the advocate that P or R wishes to exercise that right'. P and R's have rights to support from a s39D IMCA upon request. However, if the supervisory body have reason to believe that 'without the help of an advocate, P and R would be unable to exercise one or both of the relevant rights', that 'P and R have each failed to exercise a relevant right when it would have been reasonable to exercise it' or that 'P and R are each unlikely to exercise a relevant right when it would be reasonable to exercise it', then the supervisory body must instruct an IMCA under s39D MCA.

Nothing in the statute or the schedules explicitly requires a supervisory body to apply to the Court of Protection where a standard authorisation is in place and where they are in dispute with either P, R or any other third party over the detention. However, in *Neary Jackson J* held that 'there is an obligation on the State to ensure that a person deprived of liberty is not only entitled but enabled to have the lawfulness of his detention reviewed speedily by a court.'<sup>704</sup> The specific nature of this obligation is somewhat unclear. It might be satisfied by referring a person to an IMCA under s39D for support but, in some circumstances, it might also require a supervisory body to issue

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and Rule 51 (exemptions from seeking permission) exempted the relevant person's representative from seeking permission for an application under s21A MCA.

<sup>701</sup> See s50 MCA and Part 8 Court of Protection Rules 2007.

<sup>702</sup> The Community Legal Service (Financial) (Amendment) Regulations 2009 regulation 5 amended The Community Legal Service (Financial) Regulations 2000 regulation 39(ea) to exempt P and R from the financial eligibility test for public funding to bring a claim under s21A MCA.

<sup>703</sup> There are no reported decisions where a person has been refused legal aid for a s21A MCA appeal, although it has been suggested that this can be a problem (Ruck Keene and Butler-Cole, 2011). It is also reported that there have been some technical problems obtaining public funding for s21A MCA claims where authorisations have expired and been renewed. The technicalities of legal aid for the DoLS are outlined in more detail in Appendix C.

<sup>704</sup> *Neary*, [202]



proceedings themselves. This ‘final safeguard’, added in by the common-law patching up the shortcomings in the schedules, will be discussed in more detail below.

Finally, before passing on to scrutinise the safeguards in more detail it is worth observing that the schedules did not provide any safeguards for P in circumstances where a BIA found that he was deprived of his liberty but one or more of the qualifying requirements were not met.<sup>705</sup> The DoLS code simply states that ‘the managing authority, in conjunction with the commissioner of the care, will need to consider how the care plan could be changed to avoid deprivation of liberty’ (Ministry of Justice, 2008: [5.22]), yet it is unclear how this provision is to be enforced. If the BIA decides that P is not deprived of his liberty, but P or another third party do not agree, then P does not have access to safeguards such as advocacy and non-means tested legal aid to challenge the arrangements. In some circumstances P might be deprived of his liberty but not eligible for the DoLS because he is eligible for the MHA; in such circumstances nothing in the MCA or the MHA mandates health authorities to detain him under the MHA, although failure to do so may not be compatible with the HRA and Article 5 ECHR. There are thus a variety of possible scenarios where P may fall into a problematic hinterland where he is *de facto* detained, yet the practical means by which he could bring his situation to the attention of the court lies out of reach.

## 6.3 THE SAFEGUARDS

Having outlined the way the schedule works as a whole, I now turn to examine how effectively various aspects of the safeguards function in practice. In this section I draw upon doctrinal materials, a review of the available research and grey literature, interviews with DoLS team staff, IMCAs, and legal practitioners, and information obtained under the FOIA. More fine grained statistical data obtained under the FOIA or drawn from published official data are presented in Appendix C.

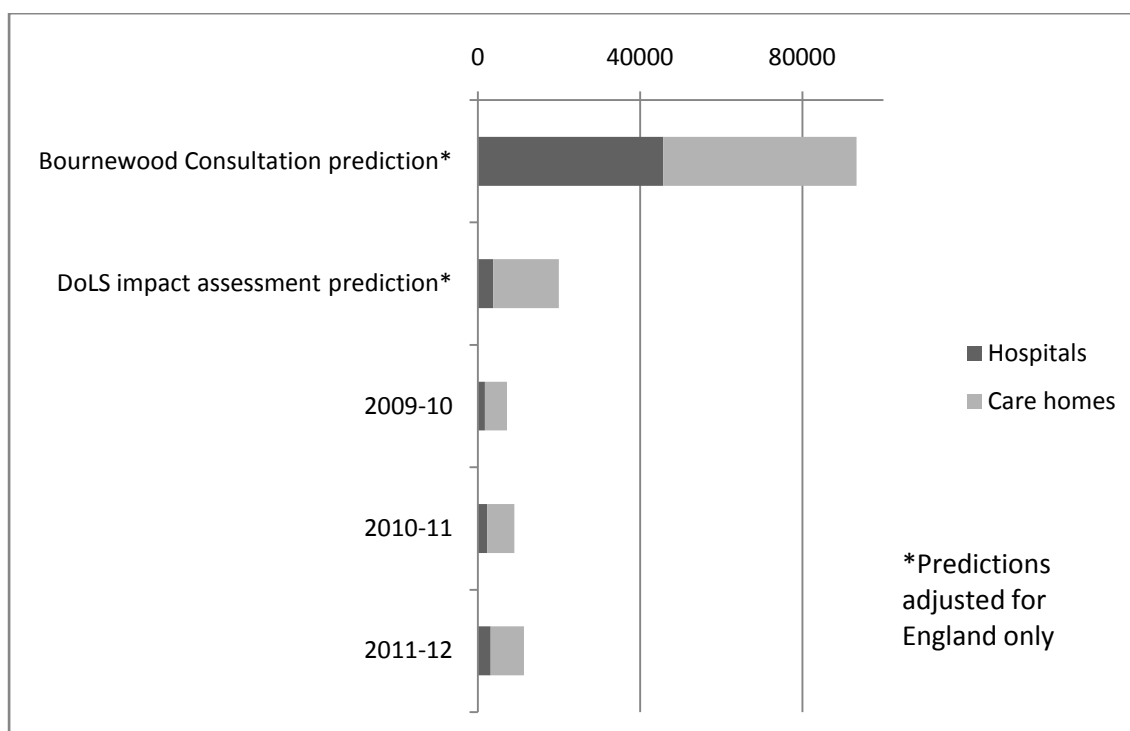
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<sup>705</sup> This point was made by Mencap in their response to the consultation on the code of practice: ‘In the flowchart on page 33, the red box containing the words “Request for authorisation declined” leads nowhere else. In some circumstances... this could be a very serious situation - for example, the person is being deprived of the liberty but it is not in their best interests’. The Mental Health Lawyers Association Observed ‘There is a lacuna in the position of an un befriended person who is assessed and where the best interests assessor concludes that not in their best interests criterion is not met [sic], but that deprivation of liberty is already occurring (paragraph 3.96). It would surely be helpful for the IMCA to remain involved whilst the steps anticipated in this paragraph are taken’. The Royal College of Psychiatrists noted that there was no duty upon the supervisory body to resolve such situations (FOIA #22). In response to the Bournemouth Consultation Age Concern noted ‘It appears that only those who are under Protective Care will have the safeguards of an appeals system. This still leaves those who are not placed in Protective Care in - but where questions are being raised as to whether they should be - in an anomalous position’ (FOIA #21).

### 6.3.1 SEEKING AUTHORISATION

A person's access to the safeguards depends upon either the managing authority or some third party triggering an application for authorisation to the supervisory body. As Figure 5 shows, annual data collected by the Department of Health shows that the overall number of DoLS applications has been far lower than initial predictions (Department of Health, 2005a; Ministry of Justice and Department of Health, 2008b; NHS Information Centre for Health and Social Care, 2010; 2011; 2012):

**Figure 5 Number of DoLS applications per year - predicted and actual data (England)**



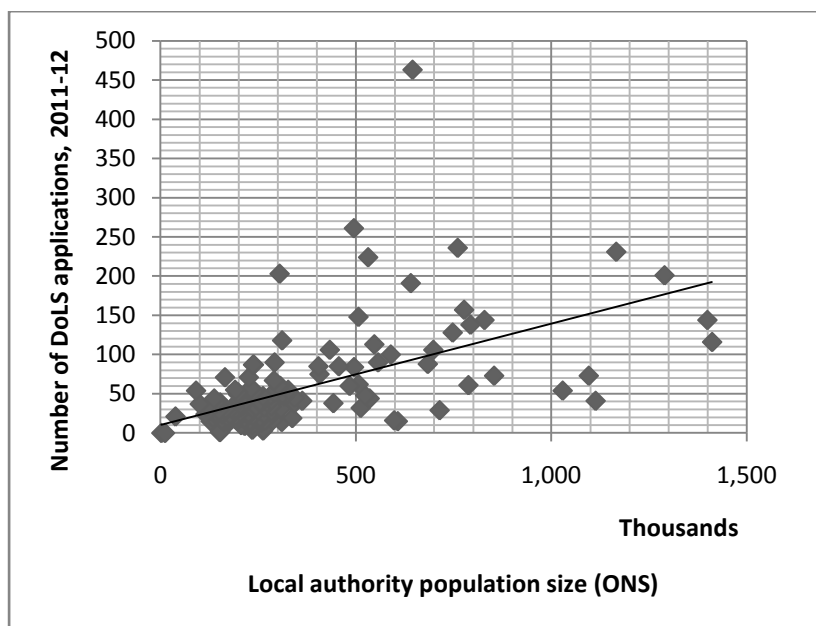
This suggests that even if the courts endorsed the 'extreme circumstances' definition of deprivation of liberty which was used in the impact assessment, large numbers of people may still be *de facto* detained. The government also predicted that the number of applications and authorisations would decline year on year as providers and commissioners learned how to avoid deprivation of liberty (Department of Health, 2007: [85]).<sup>706</sup> The number of DoLS applications in fact continued to rise until the first quarter of 2012 – coincidentally, this was the first quarter after the publication of the Court of Appeal's decision in *Cheshire West and Chester Council v P*.

In addition to the low volume of applications, there is considerable variation in the number of applications received by each supervisory body. The troubling regional

<sup>706</sup> An alternative hypothesis, Lady Hale (2009: 114) observes 'is that they will become skilled at avoiding using these procedures, just as most people managed to avoid troubling the Court of Protection even though they should have done.'

variations recognised by the Department of Health (NHS Information Centre for Health and Social Care, 2010a; 2011d; 2012f) in fact mask the true scale of variation in the number of applications received by supervisory bodies by collapsing their data together. Figure 6, below, plots the number of applications received by each local authority (NHS Information Centre for Health and Social Care, 2012g) against the size of that local authority's population (Office for National Statistics, 2009):

**Figure 6 DoLS application rates by local authority, 2011-12 (England)**



To put into context the scale of the variation shown in Figure 6, if the per-capita application rate for Leicestershire<sup>707</sup> were scaled up to reflect the whole of England, there would be over 37,000 applications per year. If the same were done for Reading<sup>708</sup>, there would be only 341. These discrepancies cannot be explained by population size.

One likely explanation is that that managing authorities within different supervisory body areas are operating with very different interpretations of what 'deprivation of liberty' means. Another possibility is that some managing authorities avoid complying with their duties to seek authorisation under the DoLS, or are discouraged from doing so by supervisory bodies themselves. There are various reasons why managing authorities and supervisory bodies might seek to avoid DoLS applications. The Mental Health Alliance writes that 'The term 'deprivation of liberty' gives a negative impression which is creating resistance on the part of service providers', and have argued that the original title of 'Protective Care' had much more positive connotations (Hargreaves, 2010: 3; Mental Health Alliance, 2012: 12). As one DoLS

<sup>707</sup> Leicestershire had the highest per-capita application rate for the whole of England in 2011-12.

<sup>708</sup> Reading had one of the lowest per-capita application rates in England, 2011-12.

team manager interviewed for this research put it, 'depriving people of their liberty isn't exactly what managing authorities want to put in their brochure'. Troke (2012: 62, 58) has suggested that judgments like *Cheshire* and *C v Blackburn and Darwen Borough Council*, discussed below, may compound this problem by undoing the 'massive effort' spent educating providers and commissioners that deprivation of liberty is 'not necessarily a bad thing'. Other factors which may discourage applications from managing authorities include 'a reluctance of care homes in particular to invite external scrutiny', and 'the length and complexity of the application forms and subsequent paperwork' (Hargreaves, 2010: 6).

The supervisory body will also have a heavy administrative burden wherever it receives an application. Shah et al (2011) estimated that the average cost of a DoLS assessment was £1277, whereas the impact assessment allocated only £600 per assessment (Ministry of Justice and Department of Health, 2008a). The Department of Health (2012a) now allocates £1200 per application for all the attendant costs of a DoLS authorisation, but this does not take into account the potential costs of litigation, and the funds are not ring-fenced. This heavy resource burden may lead to supervisory bodies discouraging managing authorities from making applications when they should do. The Mental Health Alliance (2012: 10) comments:

There is evidence that the differences in application rates are driven mainly by the different policies of the supervisory bodies, who have been largely responsible for the training and guidance given to staff of managing authorities in their areas. The statistics show that where a high proportion of applications is turned down, the application rate subsequently falls off.

In many cases the care will have been commissioned by the self-same local authority or supervisory body whom the managing authority must seek authorisation from. In those circumstances, both commissioner and provider may be motivated to avoid assessments which could result in conditions being placed on the care, or a finding that an unauthorisable deprivation of liberty is occurring. Furthermore, if there is an active dispute with P or R, granting an urgent or standard authorisation entitles them to many tools which could support them in bringing litigation against them both. As with referrals to IMCAs, discussed in Chapter 5, it is problematic that the engagement of the safeguards hinges upon actions by those whose power it is meant to hold in check. Where managing authorities and supervisory bodies are ignorant of their obligations under the DoLS, or strive to avoid fulfilling these obligations wherever possible, the DoLS will provide weak protection for detainees.

Where managing authorities have failed to apply to the supervisory body for authorisation, in theory the 'third party request mechanism' means that P or another concerned third party can request the supervisory body look into a possible deprivation of liberty. Upon receipt of a third party referral the supervisory body must assess whether or not P is deprived of his liberty unless 'it appears to the supervisory body that the request by the eligible person is frivolous or vexatious'<sup>709</sup> or the question of whether P is deprived of his liberty has already been decided and 'there has been no change of circumstances which would merit the question being decided again'<sup>710</sup>. No official data is collected on the use of the third party request mechanism, however in a FOIA request sent to all local authorities in England I found that it had only been used 165 times in the first fourteen months of operation of the DoLS (FOIA #29). Furthermore, there were significant variations in levels of its use between local authorities; one had received 25 third party requests whereas 67 of the 120 local authorities responding to the questionnaire stated that had not received any third party requests.<sup>711</sup>

Against these disincentives to apply the safeguards, there are few realistic sources of pressure to comply with them. Although *de facto* detention would implicate providers and commissioners in a human rights violation, without authorisation and its attendant safeguards the prospects of P or his family bringing this to the attention of the courts is much reduced. Against the possible vast scale of unauthorised deprivation of liberty, reports of compensation for unlawful detention awarded by the Court of Protection are rare.<sup>712</sup> Where the qualifying requirements are met but the DoLS have not been engaged, the courts may be reluctant to award damages following the ruling in *Lumba (WL) v Secretary of State for the Home Department*<sup>713</sup>. In *Lumba*, a case concerning the unlawful detention of an immigrant, a majority in the Supreme Court held that only nominal damages should be awarded where a person was unlawfully detained but where the detention would have been lawful had the appropriate procedures been followed. Furthermore, the Court of Protection's 'general rule' against awarding costs in welfare cases may mean that any potential damages payments could be offset by the

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<sup>709</sup> s69(4) Sch A1

<sup>710</sup> s69(5) Sch A1

<sup>711</sup> More detailed data on the use of the third party request mechanism is given in Table 14, Appendix C.

<sup>712</sup> The ruling in *YA(F) v A Local Authority* [2010] EWHC 2770 (COP) found that the Court of Protection has equivalent powers as the High Court to award damages in connection with breaches of the HRA. However, only two published cases report compensation being awarded for unauthorised detention. In *LB Hillingdon v Steven Neary* (2012) MHLO 71 (COP) the Court of Protection approved a consent order for Hillingdon to pay Steven Neary £35,000 in damages for unlawful detention. In *G v E & Ors* [2010] EWHC 3385 (Fam) [5] Baker J stated he would be hearing a damages claim in connection with E's unlawful detention later that year, but the outcome of this does not seem to be published anywhere.

<sup>713</sup> [2011] UKHRR 437, [2012] AC 245, [2011] UKSC 12

high costs of DoLS litigation unless – as the court does in some exceptional cases – it departs from the ‘general rule’ and awards costs to the other parties. This is likely to be especially problematic for claimants who are publicly funded, where any potential damages claims are unlikely to satisfy the merits test because any damages awarded would usually be recouped by the Legal Services Commission. One way to circumvent these problems might be to bring ‘procedural’ failings to the attention of the Local Government Ombudsman as maladministration, who can then make recommendations for compensation.<sup>714</sup>

A related question, which has not been examined in any published judgment to date, is what offence a care provider who is not a public authority in the meaning of s6 HRA715 is committing if they deprive somebody of their liberty without authorisation. Following the House of Lords’ ruling in *Bournewood* – which has not been reversed for the tort of false imprisonment – it is not obvious that they would commit any common law offence either.<sup>716</sup> In response to a question on this topic from myself to the Department of Health, an official suggested that it would be a breach of statutory duty for a private care provider to fail to seek authorisation where they should.<sup>717</sup> However, nothing in the schedules establishes a private right of action for breach of statutory duty if a managing authority fails to seek authorisation where they should; the schedules, like the MCA as a whole, appear to provide protection from liability for those applying them correctly<sup>718</sup>

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<sup>714</sup> The LGO confirmed that they had heard a small number of such cases, and shared three reports on DoLS which are reproduced in Appendix B. These reports demonstrate that the LGO is attentive to procedural failings in connection with DoLS (FOIA #19).

<sup>715</sup> See discussion of the ruling in *YL v Birmingham City Council* in Chapter 2. The amendment in s145 Health and Social Care Act 2008 specified that where care was arranged under the National Assistance Act 1948 the provider was a public authority in the meaning of s6 HRA. However, this amendment would not cover the situation of privately commissioned care, or care arranged under other statutes such as s117 Mental Health Act 1983, or – for users of supported living services – care arranged under the Chronically Sick and Disabled Person’s Act 1970. *R (A) v Partnerships In Care Ltd* [2002] EWHC 529 (Admin) held that private sector healthcare providers are public authorities in the meaning of s6 HRA for patients detained under the MHA, but the situation of those who are de facto detained or detained under the DoLS is unclear.

<sup>716</sup> Horsey and Rackley (2009: 396) have commented that the House of Lords’s decision in *Bournewood* may be incompatible with *Meering v Graham-White Aviation* [1920] 122 LT 24 (CA). In *Meering* the House of Lords found that a man was falsely imprisoned when two security guards were stationed outside his employers office, which he was brought to in connection with an alleged theft, although he did not know that they were there and would have prevented him leaving. Lord Atkins said (p. 53): ‘It appears to me that a person could be imprisoned without his knowing it. I think a person can be imprisoned while he is asleep, while he is in a state of drunkenness, while he is unconscious, and while he is a lunatic...It is quite unnecessary to go on to show that in fact the man knew that he was imprisoned.’

<sup>717</sup> Email, 12 August 2010: ‘managing authorities must act under this legislation so the action against

them is against that failure irrespective of the separate issue re care homes and the Human Rights Act isn’t it.’

<sup>718</sup> s3 Sch A1 states:

‘3(1)This paragraph applies to any act which a person (“D”) does for the purpose of detaining P as mentioned in paragraph 1(2).

without establishing any specifically actionable offence. Consequently, litigation for unlawful detention does not look like a realistic source of pressure to comply with the DoLS.

As the regulator of care services, CQC might identify possible unlawful deprivation of liberty when they are inspecting care homes and hospitals and make an appropriate referral or take enforcement action if necessary. CQC is responsible for monitoring the DoLS,<sup>719</sup> and in their first two reports they commented that their inspectors encountered situations where a person may have been deprived of their liberty but no application had been made (Care Quality Commission, 2011i; 2012d). Data collected from local authorities suggested that the CQC had only used the third party request mechanism 24 times by December 2010 (FOIA #29),<sup>720</sup> and so certainly at that stage CQC did not appear to be functioning as a reliable fallback mechanism for detecting unauthorised deprivation of liberty. It is possible that the situation has improved, however in their most recent report CQC noted that there was a need for greater awareness and understanding of the DoLS even amongst their own staff. CQC's ability to enforce compliance with the DoLS will be significantly hampered by uncertainty over what 'deprivation of liberty' actually means. The comments in their most recent report suggests that they are working from a definition of deprivation of liberty which has not taken into account the rulings in *P & Q* and *Cheshire* (Care Quality Commission, 2012d: 5, 18-20). Nevertheless, they may represent the most promising source of pressure for managing authorities to comply with the obligation to seek authorisation for a detention which may be occurring.

### 6.3.2 THE MENTAL HEALTH AND CAPACITY ASSESSMENTS

The mental health assessor must confirm that P has a qualifying mental disorder. Regulations specify that mental health assessors must either be approved doctors by s12 MHA or be 'a registered medical practitioner who the supervisory body is satisfied

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(2) D does not incur any liability in relation to the act that he would not have incurred if P—

(a) had had capacity to consent in relation to D's doing the act, and  
(b) had consented to D's doing the act.'

<sup>719</sup> Under The Mental Capacity (Deprivation of Liberty: Monitoring and Reporting; and Assessments -Amendment) Regulations 2009 the CQC 'must monitor the operation of Schedule A1 in relation to England' (regulation 2) and 'must report to the Secretary of State on the operation of Schedule A1 in relation to England as the Secretary of State may from time to time request' (regulation 3). In connection with monitoring Schedule A1, the CQC has powers to visit and interview persons accommodated in care homes and hospitals, and 'require the production of, and inspect, records relating to the care or treatment of persons' who are, or whom the CQC believes should be, subject to an authorisation under Schedule A1 (regulation 4).

<sup>720</sup> More detailed data on the use of the third party request mechanism by CQC is given in Table 14 Appendix C.

has at least three years post registration experience in the diagnosis or treatment of mental disorder'. They must also have completed the DoLS Mental Health Assessors training programme by the Royal College of Psychiatrists.<sup>721</sup> In practice, mental health assessors will often conduct the mental capacity assessment as well as the mental health assessment, although this can also be done by anybody who is eligible to act as a best interests assessor.<sup>722</sup> Whilst the MCA code of practice states 'More complex decisions are likely to need more formal assessments', neither admission to hospital nor placement in residential care services are listed among those situations where 'it may be a legal requirement, or good professional Practice, to undertake a formal assessment of capacity' (Lord Chancellor's Office, 2007: [4.42], [4.54]). Considering findings that sometimes capacity assessments for major 'best interests' decisions like a move into residential care do not take place (Emmett et al., 2012; Williams, V. et al., 2012),<sup>723</sup> the DoLS mental capacity assessment may be the first time that a person's mental capacity to decide 'whether or not he should be accommodated in the relevant hospital or care home for the purpose of being given the relevant care or treatment'<sup>724</sup> has been formally assessed by an experienced professional.

The mental health assessor must also consider how P's 'mental health is likely to be affected by his being a detained resident'<sup>725</sup> and inform the BIA of that finding. Robinson (2007: 32) points out that the substantive aspects of the mental capacity assessment under the DoLS are much more specifically defined than under the main provisions of the MCA, and import a stricter diagnostic threshold.<sup>726</sup> Between 5-7% of all DoLS applications result in a finding that P *has* mental capacity<sup>727</sup>, and so in this small minority of cases the DoLS do appear to be functioning as a safeguard against inappropriately imposed best interests decisions.

Presumably the mental health assessment is intended to satisfy the requirement established in *Winterwerp v the Netherlands* for 'objective medical expertise'<sup>728</sup> to confirm that a person has a mental disorder 'of a kind or degree warranting compulsory

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<sup>721</sup> r4 The Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008 SI 2008/1858

<sup>722</sup> r6 The Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008 SI 2008/1858

<sup>723</sup> Emmett called for stronger legal safeguards to ensure greater scrutiny of capacity assessments for decisions around changes of residence (p8).

<sup>724</sup> s15 Sch A1

<sup>725</sup> s36 Sch A1

<sup>726</sup> Although, Shah and Heginbotham (2010) express concern that this may exclude people with neurological disorders such as strokes.

<sup>727</sup> This figure was derived from the NHS Information Centre for Health and Social Care (2010b; 2011e; 2012g) data presented in Figure 16 and Figure 19 in Appendix C.

<sup>728</sup> *Winterwerp v The Netherlands*, [39]



confinement<sup>729</sup>. However, there are some difficulties with this. In a Court of Appeal hearing of the long running case *G v E & Ors*<sup>730</sup> it was argued on behalf of E that Baker J had erred in authorising a detention under s16 MCA without independent psychiatric evidence to satisfy the *Winterwerp* criteria. In that case, there was evidence from a psychologist but it was argued that as a psychologist she ‘lacked the ...competencies’ of a psychiatrist<sup>731</sup>. The OS argued that whilst the diagnosis of ‘unsoundness of mind’ required medical evidence, the justification for detention was not a medical decision requiring evidence from a medical professional;<sup>732</sup> the Court of Appeal preferred the OS’s argument.<sup>733</sup> In addition to holding that ‘objective medical evidence’ was only required for a diagnosis, the Court of Appeal also found that requiring psychiatric evidence of incapacity, as opposed to other expert evidence, ‘would, in our judgment, make MCA 2005 unworkable’.<sup>734</sup> This author, at least, sees no reason why the evidence of psychiatrists should be preferred over that of psychologists, and is cautious about excessive deference to professional hierarchies and disciplinary expertise.

The *independence* of mental capacity assessments is, however, a paramount concern from a republican perspective. In *G v E* counsel for E raised concerns that the psychologist whose evidence the court had relied upon was also ‘intimately tied up in the decision-making that violated Articles 5 and 8’.<sup>735</sup> Whilst the Court of Appeal paid considerable attention to the professional status of expert assessors, the Lords of Appeal did not turn their attention to the question of their impartiality. Whereas regulations require that the BIA is not involved in P’s care, or making decisions about P’s care,<sup>736</sup> no such provisions apply for the mental health assessor. Consequently they might – as P’s GP or another treating professional – have referred P for the treatment for which the DoLS are proposed or treatments which are otherwise implicated in the care plan.<sup>737</sup> Where P resists such care or treatment, it will be essential that doctors who have endorsed that treatment are able to separate out ‘incapacity’ from unwise decisions; something expert capacity assessors found challenging in *CC v KK*.<sup>738</sup>

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<sup>729</sup> *Winterwerp v The Netherlands*, [39]

<sup>730</sup> [2010] EWCA Civ 822

<sup>731</sup> [40]

<sup>732</sup> [46]

<sup>733</sup> [56]. It has been suggested that the ruling in *Stanev v Bulgaria* affirmed that the *Winterwerp* criteria apply even for people detained on the basis that they lack capacity for reasons other than psychiatric treatment, and thus may conflict with this ruling in *G v E* (Ruck Keene et al., 2012a: 11).

<sup>734</sup> [61]

<sup>735</sup> [40]

<sup>736</sup> The Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008 SI 2008/1858 regulation 12

<sup>737</sup> For example, where P is sedated by means of medications prescribed by his GP.

<sup>738</sup> Likewise in *CYC v PC and NC*, Hedley J complained that expert evidence came close to saying that PC lacked capacity because she made an unwise decision.

Although the MCA (but not the DoLS) code of practice does recommend obtaining ‘a second opinion from an independent professional’ where there are disputes (Lord Chancellor’s Office, 2007: [4.65]), the DoLS provided no mechanism for requiring a supervisory body to provide an independent second opinion on a person’s mental capacity. In *R (PD) v West Midlands and North West Mental Health Review Tribunal*<sup>739</sup> the High Court considered the independence of the medical member of a mental health tribunal who worked for the defendant trust. They found that his professional obligation to act in the interests of P, the wider safeguards in the system and the fact the member had not actually worked in the hospital P was detained in were sufficient to satisfy the common law test of bias and the requirements of Article 6. The mental health assessor satisfies the professional obligations aspect of this reasoning, and the courts might well regard it as relevant that a person could appeal to the court under s21A MCA as a safeguard. However, unlike the medical member of the tribunal in *R (PD)* the mental health assessor may work for the managing authority, or be otherwise involved in P’s care and treatment. Subsequent to the decision in *R (PD)* the ECtHR found in *X v Finland* that the possibility ‘to benefit from a second, independent psychiatric opinion’ was ‘an important safeguard against possible arbitrariness in the decision-making when the continuation of confinement to involuntary care is concerned’.<sup>740</sup> Failure to provide an independent second opinion contributed towards a violation of Article 5.<sup>741</sup> Although a person could potentially obtain a second opinion through applying to the Court of Protection under s21A MCA, this seems to be a very cumbersome, costly and uncertain route to bring the safeguards into compliance with Article 5.

### 6.3.3 THE BEST INTERESTS ASSESSMENT

The best interests assessment is a critical safeguard in the DoLS process. BIAs must hold specified professional qualifications with at least two years post-qualifying experience, and have attended approved BIA training.<sup>742</sup> The DoLS code also recommends that supervisory bodies consider whether assessors have ‘experience of working with the service user group from which the person being assessed comes’,

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<sup>739</sup> [2003] EWHC 2469 (Admin)

<sup>740</sup> [169]

<sup>741</sup> [171]

<sup>742</sup> They must be one of the following: an approved mental health professional; a social worker registered with the General Social Care Council; a first level nurse, registered in Sub-Part 1 of the Nurses’ Part of the Register maintained under article 5 of the Nursing and Midwifery Order 2001(b); an occupational therapist registered in Part 6 of the register maintained under article 5 of the Health Professions Order 2001(c); or a chartered psychologist who is listed in the British Psychological Society’s Register of Chartered Psychologists and who holds a relevant practising certificate issued by that Society. r5 The Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008 SI 2008/1858.

people from their cultural background or with their communication needs (Ministry of Justice, 2008: [4.14]). In conducting their assessment BIAs must have regard to P's care plan and any relevant needs assessments<sup>743</sup> and, as noted above, must determine whether or not:

- P is, or will be, deprived of his liberty;
- It is in P's best interests to be deprived of liberty
- It is necessary for P to be deprived of liberty in order to prevent harm to himself, and deprivation of liberty is a proportionate response to the likelihood of P suffering harm and the seriousness of that harm.

In determining whether or not detention is in P's best interests, the BIA must consult with those individuals specified in s4(7) MCA (Ministry of Justice, 2008: [4.65]), and they must state the name and address of every interested person whom they have consulted in their assessment.<sup>744</sup> It is worth observing that these requirements place the details of P's care and treatment under much closer scrutiny than the requirements for detention or entry into guardianship under the MHA. The list of consultees is potentially broader, but less specific, than for Approved Mental Health Professionals (AMHPs)<sup>745</sup> making applications under the MHA.<sup>746</sup>

One important contrast between the criteria for detention under the DoLS and MHA detention and guardianship regimes is the focus on the quality and suitability of the placement itself. Under the MHA the grounds for detention are located primarily in the need for the individual to be detained in the interests of his or others' health and safety, and there being appropriate medical treatment available for him.<sup>747</sup> The criteria for reception into guardianship are that 'it is necessary in the interests of the welfare of the patient or for the protection of other persons that the patient should be so received'.<sup>748</sup> These criteria direct assessors' scrutiny towards *individuals*, not *placements*, and consequently seem more attuned to individualised and medicalised models of disability, without necessarily taking into account how a particular placement interacts with a person's impairment or general wellbeing. Unlike BIA's, AMHPs are not required to

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<sup>743</sup> s39 Sch A1

<sup>744</sup> s40 Sch A1

<sup>745</sup> AMHPs are responsible for contributing towards assessments for detention or entry into guardianship under the MHA 1983, as amended. This role was previously known as the 'approved social worker'. In only a few cases is it possible for a person to become subject to a MHA regime without an AMHP's approval.

<sup>746</sup> AMHPs only have a statutory obligation to consult the Nearest Relative (see s26 MHA), but the MHA code suggests that consulting with others can also be valuable (Ministry of Justice, 2008: [4.66]-[4.70]).

<sup>747</sup> s2 and s3 MHA 1983

<sup>748</sup> s7(2)(b) MHA

investigate the quality or conditions of the place where a person would be detained to under the MHA.<sup>749</sup> It is interesting to consider what a BIA might have made, for example, of the conditions that patients at Winterbourne View were detained in, and whether those could be said to be in their best interests.<sup>750</sup>

Because BIAs must scrutinise care plans, needs assessments and consult with a range of people, they are potentially very well placed to examine the ‘micro-detail’ of the restrictions a person is living under in an institution, as well as the decision to place them in that institution. However, what, precisely, a BIA must be assessing under the DoLS is somewhat unclear as the nature of ‘deprivation of liberty’ itself is so poorly defined. Insofar as an accumulation of restrictions that a person must live under amounts to detention, BIA’s must consider whether or not those restrictions are in that person’s best interests. On that view of deprivation of liberty, the BIA’s role appears to be to examine the conditions within the institution itself – an area the courts have generally been reluctant to consider from a best interest perspective. However, if deprivation of liberty is a property of the decision to place a person in an institution rather than some other place, then the best interests decision would rest upon a comparison between those two places. In *Neary* the BIA was criticised for focussing on the restrictions that Steven Neary was subject to whilst ignoring the ‘elephant in the room’ of whether he should be in a care home or at home with his father.<sup>751</sup> However, if BIAs focus entirely on contrasts with available alternatives, the restrictions a person is subject to might fall to be scrutinised only insofar as other settings offer fewer restrictions. If there are no obvious alternatives for a person’s care, it would be unfortunate if a BIA were unable to address the question of whether or not the particular restrictions a person was subject to complied with s6 MCA and respected a person’s other rights.

If a BIA were concerned about the nature of restrictions a person was subject to they could, in theory, recommend that they be lifted or otherwise adjusted as a condition of the authorisation. DoLS team members interviewed for this research spoke enthusiastically about the transformative potential that conditions could have on the quality of a person’s care. For example, one anecdote recounted by a BIA described a young woman placed several hundred miles from her family, and who was subject to very significant restrictions in her care – including being required to wear a harness held by care staff much of the day and only leaving the care home infrequently. The young

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<sup>749</sup> *DD v Durham County Council* [2012] EWHC 1053 (QB)

<sup>750</sup> The SCR reported that no patients at Winterbourne View were subject to DoLS, although several patients were likely to be de facto detained and some of those who were supposed to be detained under the MHA 1983 were missing second opinions from medical assessors or any kind of assessment by an AMHP (Flynn, 2012).

<sup>751</sup> [74]

woman was unable to communicate verbally, but would point to a picture of her family every day and her challenging behaviours suggested she was distressed in her placement. Her family had tremendous difficulty visiting her as they worked full time and the distance was so great. The BIA recommended as a condition of the authorisation that she be given trips outside the care home on a daily basis, and that visits to her family home were facilitated on a regular basis. The BIA described having to visit the home frequently to check that the managing authority was complying with the conditions, and found that initially the home disregarded them. With regular visits from the BIA and persistent nagging the conditions were implemented. As the young woman's quality of care was transformed, so was her challenging behaviour, and eventually she was subject to so few restrictions in her care it was felt that she was no longer deprived of his liberty.

Other BIAs from other local authorities contacted for this research told similar tales of using conditions to transform a restrictive or inappropriate care plan into one where a person was able to flourish, or was at least less miserable. One, for example, described an agitated older man who had taken to dismantling the fittings of the care home in what appeared to be an attempt to escape from it. Through consulting with his family the BIA identified that he had a lifelong passion for DIY and was very likely to be bored by life in the care home, which did not stimulate him. The BIA recommended as a condition of the authorisation that facilities be provided for the man to tinker with and dismantle objects using DIY tools. The man enjoyed this opportunity, stopped trying to dismantle the care home's doors, and after a few months appeared sufficiently happy and content so that it was felt the DoLS authorisation was no longer needed. The BIA emphasised that the problem was not that the care home was 'bad', simply that it did not – until this intervention – attend to his particular needs and interests.

These anecdotes suggest that DoLS, and in particular BIAs, may have tremendous potential to tackle the kinds of micro-restrictions that can accumulate in institutional care. However, these 'good news' stories should be approached with some caution, and further research is needed to see how widespread practices like this are.<sup>752</sup> The BIAs interviewed for this research were self-selecting, as were their examples, and their enthusiasm and passion for what can be achieved under the DoLS may not be universally shared. Furthermore, the level of 'nagging' by BIAs required to ensure adherence to conditions seemed to be significant, and yet nothing in the schedules requires a BIA to visit frequently to ensure they are complied with. Oddly, this task

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<sup>752</sup> Such research may be forthcoming from a research project at Bristol University: 'Liberty, equality, capacity: The impact of the Deprivation of Liberty Safeguards on human rights and social care practice.' <http://www.bristol.ac.uk/sps/research/projects/current/rk7148/>

appears to fall to the person's representative, who may well be less confident and less well placed to ascertain whether or not they are being complied with.

Furthermore, conditions can only be set on the managing authority, not those commissioning the care, nor the supervisory body. This is problematic where compliance with conditions would require expenditure by commissioners. In the example of the man who liked DIY, the care home was operated by the local authority; this meant that conditions could be placed directly on the commissioner because they were also the managing authority. In the example of the young woman hundreds of miles from home, facilitating home visits – and even visits to the community – required considerable additional funding. In those circumstances the BIA had alerted the commissioning body to a possible breach of her human rights and they provided additional funding to facilitate her recommendations. However, it is uncertain that a commissioner would always respond in this way to such concerns, especially if they were a private individual such as a deputy.

Situations where a BIA is asked to assess a possible detention which she feels may violate a person's Convention rights pose a dilemma. Similar issues arise, although they may not always engage the Convention, if she feels that the care proposed for the person is poorly planned. On the one hand, it seems natural to suppose that detention which involves a human rights violation or poor care planning should not be authorised. On the other hand, if she does not authorise the detention the person will not benefit from any of the safeguards which they could use to challenge the placement and the BIA herself has no powers to do so on their behalf. Counter-intuitively, the legally correct and practical response may be to authorise it in such circumstances.

Strictly speaking, best interests decisions can only be made from the options that actually exist; neither the MCA nor the DoLS can make new options available.<sup>753</sup> Logically, of the options available, one must be 'best'. But it is also logically possible that this 'best' option potentially violates a person's Convention rights, where none of the available options would be Convention compliant.<sup>754</sup> The BIA is not explicitly required to consider the Convention compliance of a placement for her assessment. Guidance from the Department of Health (2010a: [18]) explicitly cautions BIA's against setting 'conditions that otherwise could have been achieved by effective care plans'. The difficulty is that this guidance offers BIA's no levers where they feel a care plan is inadequate. In such circumstances, BIA's could feasibly authorise the detention but explicitly record for the benefit of commissioners, managing authorities and supervisory

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<sup>753</sup> For exceptions to this, see section entitled '4.5.2 Best interests and resources' in Chapter 4.

<sup>754</sup> For example, a person might be so unsafe in their own home as to potentially breach Articles 2 and 3, yet the care home placement may be so restrictive, so far from family or offer such undignified care as to violate Article 8.

body alike that they regard the care plan as inadequate<sup>755</sup> and/or that a person's human rights are being violated by it. Some DoLS team members interviewed for this research commented that they had been advised against finding that a person was detained and it was not in their best interests, as this could leave a person being deprived of their liberty without any safeguards. They indicated that this guidance had been issued informally from officials at the Department of Health.<sup>756</sup> Official data on DoLS suggests that BIAs may be following this guidance; only a tiny fraction of assessments find that a person is deprived of their liberty where the qualifying requirements for detention are not met.<sup>757</sup>

Where BIA's have authorised detention in circumstances where they have concerns, the ruling in *Neary* suggests that an application by the supervisory body to the Court of Protection will be necessary. In *Neary Jackson J* criticised the BIA for not recommending a court application as a condition.<sup>758</sup> However – unusually – in *Neary* the managing authority was the local authority, who was also the commissioner and the supervisory body. Consequently the BIA could, in theory, have been able to require the local authority as a managing authority to apply to the Court of Protection. But in most situations the managing authority will not be the supervisory body and so whilst the BIA could informally recommend that such an application be made, it could not be a condition of authorisation. Where there are public law issues around care planning or resources, an application to the Court of Protection would not be the appropriate route for a challenge.<sup>759</sup> Nevertheless, few public authority commissioners would wish to defend a care plan which was defective under public law or raised serious human rights concerns as being in a person's best interests.

During the DoLS consultations it was noted that supervisory bodies would often have a conflict of interest when authorising deprivation of liberty (FOIA #22; Scott-Moncrieff, 2007). Bowen (2007: [12.13]) comments:

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<sup>755</sup> For providers, this would breach of regulatory standards (r9 The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 SI 2010/781), for commissioners this would be a breach of binding guidance on care planning (Department of Health, 2010c).

<sup>756</sup> Correspondence between myself and officials at the Department suggests that what may have been meant is that unless there are real and existing alternatives for a person to be discharged to, it is in their best interests to remain where they are as opposed to being discharged with nowhere to go. This correspondence was with a member of the now-disbanded deprivation of liberty safeguards team, dated November 2011.

<sup>757</sup> See Figure 19 Appendix C.

<sup>758</sup> [74]

<sup>759</sup> In *A Local Authority v PB* [2011] EWHC 502 (COP) Charles J stated: 'These jurisdictional points will clearly arise in respect of a number of cases in the Court of Protection, in others they will not exist and in some their existence may be open to argument. However, it seems to me that, in most cases in the Court of Protection (I hesitate to say all), that the public authorities involved, in which I include the relevant local and health authority, the Official Solicitor and the court, need to be alert to and address these jurisdictional points at an early stage.' [28]

...conflicts of interest are bound to arise where the supervisory body is also responsible for providing P with a package of care ...The hospital or care home then seek the supervisory body's authorization for P's detention. The supervisory body then has a conflict: it has already decided that P should be cared for (and therefore detained) in the hospital or care home, so how can it then decide whether that detention is authorized under Sch A1? A fair-minded and impartial observer may well conclude that there was a real possibility the supervisory body would be biased in favour of detention, rendering the decision unlawful.

The supervisory body as an organisation has very little discretion over whether or not to authorise the detention – if all the qualifying requirements are met it must, if any are not met, it cannot.<sup>760</sup> The independence of BIAs is therefore especially important. There are various means by which BIAs could potentially dampen threats of challenge to a supervisory body/commissioner about a placement. By finding that P is not deprived of his liberty, he would be entitled to no safeguards, including advocacy and non-means tested legal aid. BIA's may select a person's representative, and although the Department of Health (2010a: [11]-[12]) has warned against it, there is concern that they may overlook relatives who oppose the detention (Hargreaves, 2010; Mental Health Alliance, 2012). BIA's are the most likely conduit by which a supervisory body would be alerted to the need to make a s39D IMCA referral.

From a republican perspective, it is vital that such an important safeguard is independent and free of any conflict of interest. However there are reasons to believe that structurally the BIA is not as independent as might be desired. The schedules require that BIAs, unlike mental health assessors, must not be involved in P's care, or in making decisions about P's care, and the code of practice states that 'a potential best interests assessor should not be used if they are in a line management relationship with the professional proposing the deprivation of liberty or the mental health assessor' (Ministry of Justice, 2008: [4.13]).<sup>761</sup> Despite these provisions, the reality is that many BIAs will work alongside those responsible for making decisions about P's care – either those planning P's care or making 'safeguarding' decisions<sup>762</sup> to place P in a care home or admit him to hospital. In such circumstances a BIA may come under considerable social pressure to find that a care plan arranged by their colleagues is compatible with the MCA and the person's human rights. One BIA interviewed for this research

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<sup>760</sup> However, the supervisory body as an organisation does have discretion in decisions about referrals to s39D IMCAs, reviews and applications to the Court of Protection. If the supervisory body were concerned about the quality of a particular assessment, they could undertake a review with a fresh assessor.

<sup>761</sup> I have been unable to find the equivalent provision for this in the schedules or the regulations. It is possible I have overlooked something, but this might be an example of a discrepancy between the schedules and the code warned of by Hargreaves.

<sup>762</sup> The CQC (2011i: 8) found that it was common for supervisory bodies for DoLS teams to be based in a safeguarding team.



described themselves as ‘the dog that’s allowed to bite the master’, but not all assessors may feel secure enough in their role and confident in their independent judgment to ‘bite’ their colleagues and employers. It may be difficult to establish a ‘Chinese Wall’ within an organisation to protect BIAs and other DoLS assessors from these pressures.

Many BIAs the author has encountered give one cause to believe there are excellent, knowledgeable and independent-minded assessors working with DoLS, who approach complex care planning and human rights issues creatively and constructively. However, the centrality of their role in the safeguards means that the DoLS offer inadequate protection where a BIA’s skills, knowledge or independence are compromised. In *Neary*, for example, Jackson J found all the BIAs’ assessments to be inadequate, yet it took nearly a year for the case to reach court. The problem is that whilst a great deal of good can be done by BIAs, much of this is contingent upon their good judgment and good faith. From a republican perspective this is unsatisfactory – domination results from structures which do not offer protection against the caprices and whims of individuals. In the words of the ECtHR in *HL v UK*:

...the very purpose of procedural safeguards is to protect individuals against any ‘misjudgments and professional lapses’.<sup>763</sup>

#### 6.3.4 THE RELEVANT PERSON’S REPRESENTATIVE

The DoLS code of practice describes P’s representative as ‘a crucial role in the deprivation of liberty process, providing the relevant person with representation and support that is independent of the commissioners and providers of the services they are receiving.’ (Ministry of Justice, 2008: [7.2]). Under the DoLS, P’s representative has certain formal duties specified by the regulations:<sup>764</sup>

- To maintain contact with the relevant person,
- To represent the relevant person in matters relating to, or connected with, the deprivation of liberty, and
- To support the relevant person in matters relating to, or connected with, the deprivation of liberty.

Representatives have rights to be kept informed of given records of assessments and other developments connected with P’s detention under the DoLS. They also have

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<sup>763</sup> *HL v UK*, [121]. The ECtHR endorsed Lord Steyn’s comments that the decision in *Bournewood* ‘...places effective and unqualified control in the hands of the hospital psychiatrist and other health care professionals. It is, of course, true that such professionals owe a duty of care to patients and that they will almost invariably act in what they consider to be the best interests of the patient. But neither habeas corpus nor judicial review are sufficient safeguards against misjudgments and professional lapses in the case of compliant incapacitated patients.’

<sup>764</sup> r12The Mental Capacity (Deprivation of Liberty: Appointment of Relevant Person’s Representative) Regulations 2008 SI 2008/1315

powers to request reviews of P's detention, to apply to the Court of Protection under s21A MCA without permission, and 'gold plated' entitlements to legal aid for that purpose.

Because P is likely to face many practical obstacles initiating a formal challenge to his detention under the DoLS, he will be very reliant on the representative to trigger a review or litigation on his behalf. Difficulties may therefore arise where a representative is unwilling or unable to initiate a challenge on behalf of P. In some circumstances representatives may support the detention, even where P is objecting to it; it is quite possible that a representative may have helped to choose the care which constitutes a detention themselves. In *A v A Local Authority & Ors*<sup>765</sup> Mr A's son, S, was appointed as his representative, but S 'did not support A in exercising his right to challenge the authorisation'<sup>766</sup> and felt 'he would dislike wherever he was.'<sup>767</sup> As a result of S's unwillingness to support Mr A in challenging his detention, the supervisory body appointed a different representative who did support him to. Whilst it is laudable that the supervisory body took action to support Mr A's right to challenge an authorisation they themselves had issued, it is not obvious that they were obliged to. The regulations stipulate that the appointment of a representative should be terminated where the supervisory body is satisfied that the representative is 'not maintaining sufficient contact' with P, or 'is not acting in the best interests of' P<sup>768</sup>, but it is not explicitly stated that representatives must help P to challenge decisions which both the representative and the supervisory body regard as being in P's best interests. There is certainly an argument that it is always in a person's best interests to be supported and able to exercise their rights of appeal under Article 5(4). However, this has never been made explicit in case law and – as will shortly be discussed in connection with litigation friends – there are reasons to believe that not everybody would agree with this statement.

Since it can never be assumed that simply because a representative is in agreement with professionals the detention must be justified,<sup>769</sup> the representative cannot be regarded as failsafe safeguard against arbitrary detention, or a guarantee that P is able to exercise his Article 5(4) rights of appeal should he want to. Furthermore, representatives may not find it easy to initiate a challenge under s21A MCA even if they themselves oppose the detention. It is difficult to think of a representative more

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<sup>765</sup> [2011] EWHC 727 (COP)

<sup>766</sup> [4]

<sup>767</sup> [13]

<sup>768</sup> r13 The Mental Capacity (Deprivation of Liberty: Appointment of Relevant Person's Representative) Regulations 2008 SI 2008/1315

<sup>769</sup> In the trinity of ECtHR cases on deprivation of liberty – *Stanev, DD* and *Kędzior* – the person's guardian was in agreement with other professionals that a person should be placed in the institution against their objections.

dedicated to securing the release of a detainee than Mark Neary, the father of Steven Neary. He spent almost a year campaigning online and in the media to 'Get Steven Home',<sup>770</sup> yet legal action was not initiated until his son had been detained for nearly a year. In part the court found this was due to the Council's failure to ensure he obtained the support of a s39D IMCA, and in part this was because the Council had misled him into believing that Steven would soon be discharged back into his care when in fact they were secretly planning to send him to a hospital many hundreds of miles away. Another reason, not discussed in the judgment, is the considerable difficulty Mark Neary had in finding a solicitor – having contacted over fifty law firms before finding one who was prepared to take on his case,<sup>771</sup> and having previously been ill-advised by a major law firm that he was not entitled to legal aid to take the case to court (Kenber, 2011b).

In addition to these practical and tactical problems, representatives may also have good reason for being cautious about 'rocking the boat' with those whom they rely upon to commission or provide care for their loved ones. If Steven was ever to return home, Mark Neary would be reliant upon the self-same local authority he was expected to challenge using the DoLS to put in place a care plan to support him as a carer and Steven himself. In *Neary Jackson J* recorded:

Speaking of his relations with the social worker, [Mark Neary] said that he found them quite awkward ever since the meeting in January where the idea of reviewing the support package was brought up. He said that this fear remained "tattooed on my brain" and from that point on he was worried about the consequences of rocking the boat. Indeed, when he finally put his foot down on 9 July, and directly asked for Steven's return, Hillingdon's immediate response was that the necessary support package would not be made available. Mr Neary became understandably emotional when describing how powerless he had felt.<sup>772</sup>

This passage is testament to the subjective experience of being dominated by an organisation upon whom one depends, who is capable of taking decisions which may have very significant consequences for one's life, where one is not secure in the

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<sup>770</sup> Mr Neary set up a Facebook group called 'Get Steven Home' which attracted thousands of members and growing media attention. He started a petition to secure the release of his son, and worked hard to co-operate with Hillingdon Council to arrange for him to be released back into his care. Some of his travails are described in the judgment in *Neary* but they are also described by Mark Neary himself in his book (Neary, 2011).

<sup>771</sup> Declaration of interest: I was a member of Mark Neary's Facebook group and saw that he had posted that he needed to apply to the Court of Protection urgently to prevent Steven being moved to a hospital in Wales the following week, but was unable to find a solicitor. I contacted him and offered to help him ringing round law firms on the Mental Health Lawyers Association list. I myself contacted tens of firms, and encountered a small number who offered to take the case to 'judicial review' in the administrative court or to a tribunal, suggesting they lacked the expertise to act in a DoLS case. By coincidence, a solicitor from Exeter of my acquaintance was in London that day and was able to visit Mark Neary and lodge an urgent application to the Court of Protection.

<sup>772</sup> [146]

knowledge that one can effectively challenge them. It is now two years on from the ruling in *Neary* and the family are reported to be facing losing their home due to a decision by Hillingdon Borough Council to withdraw housing benefit despite there being no change in their financial status (Kenber, 2012). It is important to bear in mind that both P and R are likely to have an ongoing relationship of dependency upon the local authority, and the fear of retributive withdrawal of forms of support they rely upon may have a bearing on their willingness to exercise their rights of appeal.

One further weakness in the role of representative lies in the selection process. As noted, where a BIA is satisfied that P lacks the mental capacity to choose his own representative, and there is no deputy or LPA with the requisite authority to select one,<sup>773</sup> the BIA will select the representative herself. The Mental Health Alliance has found evidence that:

...in some cases close relatives who opposed the authorisation were being passed over in favour of paid representatives, or other relatives who supported the action. Where this is done, it effectively allows DoLS to be used to override an objection by the closest relative to a hospital or care home placement without going to court as would previously have been necessary, and to deny them access to the information they would need in order to mount a legal challenge. If this is happening to any significant extent it would be ironic, as the whole scheme came about as a result of a successful challenge by carers who had been deliberately excluded.<sup>774</sup>

The Department of Health (2010a: [11]) has cautioned supervisory bodies against avoiding challenges by appointing only representatives who support the detention. The Mental Health Alliance (2012: 12) recently called for clarification in the DoLS code of practice that possible representatives 'should not be regarded as acting contrary to the detained person's best interests solely because they object to the authorisation or are likely to challenge it'. However, merely issuing guidance does not do much to guard against potentially arbitrary decisions in the appointment of representatives.

One possibility might be to adopt a 'statutory list' which offers supervisory bodies very little discretion in who they appoint as representative – such an approach is taken for the appointment of the Nearest Relative who occupies a similar role under the MHA.<sup>775</sup> In recognition of the fact that not everybody may want the first person on this statutory list to be their Nearest Relative<sup>776</sup> a person may apply to the county court for

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<sup>773</sup> For reasons discussed in Chapters 4 and 5, this is especially likely to be the case for people with learning disabilities who tend not to have made LPAs and where welfare deputyships are so rarely awarded.

<sup>774</sup> Hargreaves (2010: 10)

<sup>775</sup> s26 MHA 1983

<sup>776</sup> Or as solicitor David Hewitt (2008) puts it, 'when your nearest isn't your dearest'.

their displacement.<sup>777</sup> If there are concerns about the Nearest Relative the AMHP or any other relative of the detained patient or person with whom they reside might also apply for them to be displaced. Arguably an application to court asks a lot of a person who is undergoing detention on the basis of mental disorder, and so it might be more desirable if detainees could exercise a veto<sup>778</sup> on the appointment of a particular representative. Meanwhile, a requirement that supervisory bodies must apply to court to displace representatives who might challenge their decisions could guard against this particular potential subversion of the safeguards.

By way of comparison, the powers of representatives under the DoLS are substantially weaker than those of the comparable role of Nearest Relative under the MHA 1983. Nearest Relatives can object to a person's detention under s2 or s3 MHA, reception into guardianship or discharge them from those regimes. If the detention or guardianship is to go ahead, or discharge to be prevented, the Nearest Relative must be formally displaced from their role by a court. If, as Richard Jones argues should have been the case, an amendment to guardianship under the MHA had been introduced instead of the DoLS, relatives opposing a detention would have substantially greater powers to prevent it or bring it to an end. If the detaining and guardianship authorities were committed to that course of action, it would be incumbent upon them – not the detainee or the relative – to apply to court. This represents one of the most significant differences between the MHA and the DoLS in the balance of power between detaining authorities and detainees and their families. It is worth reflecting that if Steven Neary had been subject to guardianship, his father could have discharged him simply by writing a letter to the local authority,<sup>779</sup> and either Hillingdon would have had to comply with that request or defend their decision in court many months sooner than they did under the DoLS.

### 6.3.5 THE PART 8 REVIEW

The *Bournemouth Consultation* initially proposed that the procedure which became the Part 8 Review could operate as a 'first tier' review process, to alleviate pressure on the courts (Department of Health, 2005a: [5.14]-[5.16]). This suggestion was robustly rejected by consultees, and the government concluded that 'it might be seen as interfering with the right, under Article 5(4), of appeal to a court and delay the

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<sup>777</sup> s29(1) MHA 1983

<sup>778</sup> In the event a person vetoed all possible or appropriate representatives a person could be appointed a paid representative.

<sup>779</sup> s23 MHA 1983

speedy decision by such a court on the lawfulness of instances of deprivation of liberty' (Department of Health, 2006d: [41]). Consequently, Part 8 Reviews are better understood as a mechanism that allows a supervisory body to adapt to changes in circumstances, or any internal concerns they may have about the quality of assessments or compliance with conditions, rather than a quasi-appeal mechanism for detainees and representatives.

The Part 8 Review procedure as it stands would not be a robust safeguard against misjudgments or poor assessments by a supervisory body where they did not entertain such concerns. Although both P and R can request a Part 8 Review, the supervisory body is not obliged to carry out a review 'if no qualifying requirements appear to be reviewable'.<sup>780</sup> There is no guarantee that the assessments undertaken for the purposes of a review would not replicate the defects of the very assessments which P or R seek to challenge; this was a problem in *Neary* with the BIA's assessments and reviews. There is no right to a fresh assessor or an independent second opinion. The review process might be used by supervisory bodies to get a second opinion on an assessment which they or P or R have concerns about, but nothing compels them to.

Like other aspects of the safeguards which depend upon discretionary decision making, the use of the Part 8 Review mechanism appears to be highly variable. No official statistics are collected on the use of Part 8 reviews, but data collected by BBC journalist Matthew Hill found that of 103 local authorities surveyed using the FOIA only 226 Part 8 Reviews had been requested by P or R in 2010-11 and 58 (56%) of supervisory bodies had received no such requests (FOIA #30). The Mental Health Alliance (2012: 11) comment that the review process 'is still little used by detained persons or their representatives'. They also recommend that supervisory bodies should be required by statute to give written reasons where they decline to undertake a Part 8 Review requested by a representative (p12). Supervisory bodies who are open and responsive to challenges may exercise good judgment to use the review process to guard against arbitrariness in their initial decisions. However, Part 8 offers little protection against those supervisory bodies who both make poor initial decisions and poor subsequent decisions in the conduct of reviews.

### 6.3.6 SECTION 39D IMCAS

In situations where P and/or R might struggle to understand and exercise their rights under the DoLS, support from a s39D IMCA will be vital. Given the complexity of the DoLS, this seems likely in the majority of cases. The role of a 's39D IMCA' is

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<sup>780</sup> s110 Sch A1

therefore distinct in several important respects from that of IMCAs under the main provisions of the MCA. Unlike the IMCAs discussed in Chapter 4, s39D IMCAs are available upon request to support P, and to support P's family if they are acting as his representative. Furthermore, the role of the IMCA is not primarily to gather information for decision makers, but to help P and R to understand and exercise their rights. The drafting of s39D leaves s39D IMCAs with little discretion in whether or not to help P or R apply to court; if P or R wishes to exercise that right, then the IMCA *must* assist them in doing so. This is a much stronger and clearer right to support in challenging a decision made under the DoLS than a person has under the main IMCA provisions discussed in Chapter 5.

Supervisory bodies have a proactive duty to make referrals for an IMCA to support P or R where it seems to them that without that support P and R would struggle to exercise their rights of appeal and review. On paper, therefore, it looks as if we have a safeguard which should guarantee that if P struggles to exercise his right of appeal, and R is unable or unwilling to help him, the s39D IMCA should step into the breach to support and enable him to exercise his Article 5(4) rights. In *Neary Hillingdon's* failure to appoint a s39D IMCA in a timely fashion contributed towards Jackson J finding that Steven Neary's Article 5(4) rights had been breached.<sup>781</sup> *Neary* is testament to the transformative input an IMCA can make. According to Jackson J 'The first best interests assessment that deserves the name' was the report of the IMCA<sup>782</sup>, 'For the first time, professional support was given to Mr Neary's arguments'<sup>783</sup> and 'This report pointed the way towards a different outcome for Steven'<sup>784</sup>. In the absence of a mechanism which would refer P's case to court automatically, the s39D IMCA is likely to offer the strongest means by which the obstacles to a court review in P's path could be circumvented.

In practice, however, s39D MCA does not appear to be functioning in the way it was intended. This much is obvious from the tiny trickle of DoLS appeals which have actually reached the court, discussed in more detail below. The s39D mechanism appears to be breaking down both at the point of referral, and at the point where s39D IMCAs themselves should be helping P to transmute any objections into an appeal.

Analysis of official data on the number of s39D IMCA referrals for each local authority in 2010-11 (Department of Health, 2011b) revealed that 51 of 145 local authorities *had not made a single referral* under s39D; 26 of those local authorities had

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<sup>781</sup> [193]-[194], [197], [202]

<sup>782</sup> [155]

<sup>783</sup> [124]

<sup>784</sup> [124]

granted over 10 authorisations and one had granted as many as 132.<sup>785</sup> The Mental Health Alliance has also found evidence of underuse of s39D IMCAs, and comments that:

...the implication is that the requirements of Section 39D are generally being disregarded and that the vast majority of family representatives are receiving no support in grappling with an opaque and impenetrable system.<sup>786</sup>

Even where an IMCA has been appointed, the evidence suggests they are very rarely supporting P to appeal against his detention. Data from the Court of Protection suggests that 2 out of 30 s21A MCA applications between April 2009 and January 2011 were made by IMCAs, with three more being made under s15 MCA (FOIA #15).<sup>787</sup> However, it is more likely that IMCAs would help P to initiate litigation in his own name than make an application themselves. Yet, the recorded data suggests that IMCAs are involved only rarely in even assisting P to appeal. As noted in Chapter 5, the Department of Health (2010d; 2011b) reports that there were a total of ten cases between 2009-11 where an IMCA referral led to an application to the Court of Protection – inclusive of both DoLS and litigation connected with other decisions under the MCA. These data, in combination with the data on the overall low volume of s21A applications discussed below, suggests that there may be widespread failure on the part of s39D IMCAs to support and enable P to exercise his Article 5(4) rights in accordance with their statutory duty.

It is unclear why this is the case. The problems of resources, independence and preserving future relationships with decision makers outlined in Chapter 5 may form a partial answer. It is possible that IMCAs themselves do not understand that s39D imposes a much stronger duty upon them to help P to apply to court than in their role elsewhere under the MCA. It may be that IMCAs are interpreting their role to support P in exercising his rights of appeal as only being engaged where they regard an appeal as being in P's best interests. From the perspective of Article 5(4) which appears to bestow an absolute right of appeal against detention, not one which is conditional upon a person

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<sup>785</sup> This data breakdown for 2009-10 was not published, and I encountered considerable difficulties obtaining it under the FOIA (FOIA #27). When, after a year, the Department of Health agreed to share the information with me they issued the following warning: 'The data by category for 2009/10 were not published due to feedback from advocates, care homes and local authorities, which showed that there was considerable confusion over the understanding and recording of the different categories of DoLS in the first year. The decision was made at the time that the numbers inputted under the three categories were unreliable and unusable.' I have decided not to use the data in this thesis, but the health warning speaks volumes about the lack of clarity in the first year of the DoLS over the role of s39D IMCAs.

<sup>786</sup> Hargreaves (2010: 11)

<sup>787</sup> A more detailed breakdown is given in Table 15 Appendix C.



having capacity or it being in their best interests, this would seem to be a highly dubious interpretation. In *Stanev, DD and Kędzior*, their mental capacity and their best interests did not enter the ECtHR's discussion of their right to seek a court review of their detention. In *Neary*, Jackson J stated 'there is an obligation on the State to ensure that a person deprived of liberty is not only entitled but enabled to have the lawfulness of his detention reviewed speedily by a court'<sup>788</sup>, and made no mention of Steven Neary's mental capacity.

In the context of detention under s2 MHA, the House of Lords held in *MH v Secretary of State for the Department of Health & Ors*<sup>789</sup> that although an automatic referral to the tribunal is not necessary for a person who lacks mental capacity, every 'sensible effort should be made to enable the patient to exercise that right if there is reason to think that she would wish to do so'.<sup>790</sup> The question of whether Article 5(4) is qualified with reference to incapacity will be discussed below, but it certainly seems far from conclusively the case in light of the ruling in the ruling in *MH*. Further research is needed to understand why IMCAs appear to be failing to live up to their role, and such research is of urgent importance given their centrality to ensuring the DoLS offer adequate protection against arbitrary detention.

### 6.3.7 ACCESS TO THE COURT OF PROTECTION

I argued in Chapter 5 that the Court of Protection is one of the most important safeguards against arbitrary mental capacity assessments and best interests decisions; in the context of DoLS it also represents the most important safeguard against arbitrary detention under Article 5(4). Yet there are reasons to be concerned that whilst access to the court may be improved under the DoLS, many of the procedural difficulties discussed in Chapter 4 remain an area of concern for appeals made under s21A MCA. Nevertheless, the DoLS do seem to provide a framework which facilitates *more* legal challenges by P himself, even if they do not facilitate *many*. When asked how often P was the applicant to the Court of Protection, judges and the OS had responded that it was quite rare, but the OS added this qualification: 'except in section 21A applications.'

There are several reasons why the DoLS may offer an enhanced route to court over the ordinary s15/s16 MCA procedure. One problem discussed in Chapter 4 was that P might not understand his rights of challenge, yet the DoLS requires the managing authority and any s39D IMCA to explain the authorisation to P and his rights of appeal. Thus DoLS potentially circumvent the rights-awareness issues which prevented people

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<sup>788</sup> *Neary*, [202]

<sup>789</sup> [2005] UKHL 60; [2006] 1 AC 441

<sup>790</sup> [24]

from using the Court of Protection to challenge best interests decisions. Another obstacle facing both P and P's family was difficulties securing funding for litigation – yet the DoLS offers 'gold plated' legal aid for an application to court. P's representative does not have to secure the permission of the Court of Protection to initiate proceedings, whereas ordinarily friends and family would have to and often do not obtain it (Judiciary of England and Wales, 2010; 2011; Series, 12a). Where P is unable to secure the support of R or other third parties to appeal, the supervisory body is statutorily obliged to refer him to a s39D IMCA, who in turn is statutorily obliged to assist him. If all else fails, Jackson J held in *Neary* that supervisory bodies themselves should refer an ongoing dispute to court in order to enable a person to exercise their Article 5(4) rights of appeal.<sup>791</sup>

Yet despite the substantial improvements made by the DoLS on rights of appeal elsewhere under the MCA, the number of appeals under s21A MCA has been extremely low. The impact assessment, for reasons which are entirely unclear, predicted that only 2.5% of all authorisations would result in an application to the Court of Protection (Ministry of Justice and Department of Health, 2008a).<sup>792</sup> However the number of reported appeals in the first year of the DoLS fell far below even this conservative estimate. Drawing from data supplied to me by the Court of Protection (FOIA #16)<sup>793</sup> and comparing them against official statistics on DoLS authorisations, it appears that there were 19 s21A MCA applications in 2009-10 for 3297 DoLS authorisations (0.6%), and 40 in 2010-11 for 4951 DoLS authorisations (0.8%). It is true that the duration of DoLS authorisations has typically been lower than anticipated by the impact assessment, and it is likely that some of these authorisations may relate to multiple authorisations for the same individual.<sup>794</sup> A roughly equivalent number of court hearings appear to have come about through the supervisory body themselves applying to the Court of Protection in connection with a deprivation of liberty under the MCA – although many of these will be cases which cannot be authorised under Schedule A1 (discussed below).

This seems an astonishingly low number of appeals for a mechanism whose primary function is to ensure people are able to exercise their Article 5(4) right to a court review of their detention. It compares very poorly, for example, with the rate of appeals

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<sup>791</sup> 'Significant welfare issues that cannot be resolved by discussion should be placed before the Court of Protection, where decisions can be taken as a matter of urgency where necessary', *Neary v Hillingdon Borough Council*, [33]

<sup>792</sup> This figure seems especially extraordinary when one considers the reason the government gave for projecting only 21,000 people might need safeguards was that Bournemouth represented an 'extreme' set of circumstances. Yet if these circumstances are so 'extreme', surely more than 2.5% of detainees and their families would object to them?

<sup>793</sup> Please see Figure 20 Appendix C for a more detailed breakdown of these data.

<sup>794</sup> See Figure 18, Appendix C, for the durations of authorisations under the DoLS, 2009-11.

under s2 MHA which must be initiated by detainees, and even that is considered to be concerning low (Bartlett and Sandland, 2007: 376).<sup>795</sup> This low volume of applications is likely to be linked to the defects in the safeguards discussed above – BIAs selecting representatives who are less likely to challenge the detention; representatives who are unwilling, unable or too cowed by the supervisory body to trigger the appeal mechanism; low rates of referral to s39D IMCAs, and s39D IMCAs’ failures to understand and comply with their statutory duty to support appeals. It is also reported that there can sometimes be difficulties convincing the Legal Services Commission that ‘best interests’ matters considered by the Court of Protection in connection with an application under s21A MCA are not s15/s16 MCA matters which do not entitle a person to non-means tested legal aid (Ruck Keene et al., 2012d).<sup>796</sup> The clear exhortation to bring disputes to court in *Neary* appears to have resulted in a marked increase in the number of s21A MCA appeals and DoLS cases before the Court of Protection. Unfortunately, more recent data on the number of appeals since *Neary* was not available from the Court of Protection at the time of writing.<sup>797</sup>

Further evidence that the volume of DoLS challenges is closely linked to a supervisory body’s willingness to support a person in the exercise of their Article 5(4) rights is provided from a finding that s21A MCA challenges appear to cluster around certain supervisory bodies. In a survey of local authorities in England (FOIA #29) I asked how many DoLS related court cases each local authority had been involved in. By November 2011 they reported having been involved in 33 s21A MCA cases.<sup>798</sup> One hundred and one local authorities had not been involved in any DoLS-related litigation at all, twelve local authorities had been involved in one s21A MCA challenge, seven had been involved in two s21A MCA challenges and one local authority had been involved in seven s21A MCA challenges. That particular local authority also had a noticeably high volume of third party requests for Part 8 Reviews (FOIA #30), a medium volume of applications received and granted under the DoLS compared with other local authorities,

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<sup>795</sup> According to the CQC (2011f) in 2010-11 there were 7,103 applications to tribunals by s2 detained patients, of a total of 19,163 s2 detained patients overall (NHS Information Centre for Health and Social Care, 2011c). This suggests 37% of people detained under s2 MHA exercise their right to apply to a tribunal.

<sup>796</sup> For a more detailed discussion of difficulties securing public funding for DoLS appeals, please see Appendix C.

<sup>797</sup> The Court of Protection do not keep a single database from which they could easily extract the number of DoLS appeals; they must be counted by hand in each regional court. I am extremely grateful to the Court of Protection staff, and Mr James Batey in particular, for doing this for me twice already. I also understand that they are working towards a system which would make it easier for them to extract these data.

<sup>798</sup> See Table 16 Appendix C for a more detailed breakdown of these data. These data seem roughly compatible with the data shared with me by the Court of Protection, allowing for slightly different timescales and the Court of Protection also hearing applications from Primary Care Trusts, local authorities who did not respond and local authorities in Wales.

and had made an above average number of referrals to s39D IMCAs. Whilst at face value a higher rate of challenge might be regarded as indicative of poor decision making, I would contend that it is more likely to represent a local authority who is more committed than most to upholding P's Article 5(4) right to challenge their decisions. Another relevant factor may be the development of specialist legal expertise in DoLS in that region, and strengthening connections between IMCAs and solicitors who are capable of taking on DoLS-related work.

A further obstacle to P exercising his Article 5(4) rights of appeal is securing a litigation friend who is willing to pursue it. As for cases in the Court of Protection heard under s15/s16 MCA, the litigation friend for s21A MCA appeals will often be the OS, although there has been one reported case of a paid representative acting as a litigation friend in a s21A MCA challenge.<sup>799</sup> I tried to obtain information under the FOIA and by asking my local MP to table a written question in parliament as to whether the OS ever discontinues appeals under s21A MCA brought by P (FOIA #32; #33). Unfortunately, the OS is not bound by the FOIA<sup>800</sup> and the Parliamentary Under-Secretary for State for the Ministry of Justice was unable to answer this question.<sup>801</sup> However, in an interview for this research I was able to ask the OS himself whether he operated a policy of always, automatically, challenging a deprivation of liberty authorisation if P was objecting. He responded 'I would apply the best interests test and if it was unarguable than I wouldn't run it', and emphasised that his role was different from that of a mental health solicitor.

This raises the question of what case a litigation friend should pursue on behalf of P, and what constitutes an 'arguable' case, rehearsed in Chapter 4.<sup>802</sup> In essence, litigation friends will sometimes face an uncomfortable choice between assisting a person in bringing their arguable claim before a court, although they do not believe either the litigation or their preferred outcome to be in their best interests, or else withdrawing the claim without the court determining the lawfulness of the detention. If anything the arguments in favour of litigation friends pursuing appeals, no matter how futile they appear to be, are stronger in the context of Article 5(4) than elsewhere. The approach of litigation friends under the DoLS contrasts starkly with appeals against detention under the MHA. The right to bring an unarguable appeal against detention under the MHA seems well established; approaching 90% of appeals to tribunals under the MHA fail

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<sup>799</sup> *AB v LCC* (A Local Authority)

<sup>800</sup> The Office of the Official Solicitor does not appear upon the list of bodies bound by the FOIA given in Schedule 1 FOIA.

<sup>801</sup> *Hansard* HC vol 527 col 954W (9 May 2011)

<sup>802</sup> See section in Chapter 5 entitled 'Litigation friends' decisions about whether, and how, P's case should be advanced'.

(Care Quality Commission, 2011f). The Law Society's (2011) guidance to solicitors representing clients in mental health tribunals emphasises that the threshold for capacity to litigate is very low, and states that 'it would be in a rare case that to seek a client's discharge in accordance with his or her express wishes would not be 'properly arguable'. In *Waite v The United Kingdom*<sup>803</sup> the ECtHR found that 'an applicant is not required, as a precondition to enjoying [the protection of Article 5(4)], to show that on the facts of his case he stands any particular chance of success in obtaining his release'. It is very difficult to reconcile this ruling to the practice of discontinuing a s21A MCA appeal on the grounds that it might be futile.

It is possible that the OS cannot withdraw appeals initiated under s21A MCA without the consent of the court itself, although this is somewhat unclear at face value. Under Civil Procedure Rule 21.10 no settlement, compromise or payment in proceedings can be reached without the consent of the court, but there is no obvious parallel rule in the Court of Protection Rules 2007. Nevertheless, a litigation friend can only be appointed for P by the court, and so proceedings must always be initiated before a litigation friend could seek to withdraw them. Presuming the Court of Protection observes the convention under CPR 21.10,<sup>804</sup> the court itself would have to agree to the OS withdrawing any appeals which he regarded as 'unarguable'. It is disturbing in itself that there is so little information in the public domain about the procedure that litigation friends and the Court must follow if proceedings are withdrawn on behalf of P.

It is difficult to reconcile the practice of withdrawing P's appeal against his detention before the court has reviewed its lawfulness, to his rights under Article 5(4).<sup>805</sup> No ECtHR case has ever suggested that a person's Article 5(4) rights hinge on their capacity and best interests, and there are sound reasons for believing they should not. As discussed in Chapter 5 the OS bases his case on expert evidence, but expert evidence can be wrong – as *CC v KK* so strikingly showed. The court is better placed to consider all the amassed evidence, and it is increasingly clear that judges may be obliged to meet appellants in person where their mental capacity is in dispute, and

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<sup>803</sup> (App no 53236/99) (2003) 36 EHRR 54, [2002] ECHR 804

<sup>804</sup> Under s1 Civil Procedure Act 1997 the Civil Procedure Rules bind the civil division of the Court of Appeal, the High Court, and county courts. However, although sometimes High Court judges from the Family Division sit in the Court of Protection it is not a division of the High Court in its own right. Under s47(1) MCA it 'has in connection with its jurisdiction the same powers, rights, privileges and authority as the High Court.' It is not clear that this means it is a High Court for the purposes of the Civil Procedure Act. However, it could be argued that the requirement for a litigation friend to seek the court's consent under s21.10 is a power or source of authority for the court, and hence that is imported into the Court of Protection by s47(1) MCA.

<sup>805</sup> In interview I asked the OS whether it might not be the case that P has an unqualified and absolute right to be enabled to appeal against his detention under Article 5(4). The OS responded that this was an arguable point which at some stage the court will almost certainly have to determine in light of the ECtHR authorities.

perhaps also for decisions about detention.<sup>806</sup> Failing to consider and determine an appeal against detention would also appear to conflict with the Court of Protection's own case law in *A Local Authority v A*, where it held that:

...the [MCA] has laid down stringent conditions for the deprivation of liberty, and that the court cannot simply act as a rubber stamp, however beneficial the arrangements may appear to be for the individual concerned. In the instant case, A wishes to challenge the authorisation, which deprives him of his liberty. Parliament has decreed that he should be entitled to do so, and has created safeguards to protect those deprived of their liberty against arbitrary action.<sup>807</sup>

Whether the OS and the Court of Protection are entitled to allow P's appeal to be withdrawn without the court determining it will surely, eventually, fall to be decided by a court.

As for supporting P's rights to challenge 'best interests' decisions, the logical consequence of patching up the safeguards to strengthen P's right for his detention to be reviewed by a court, is that there will be more litigation in the Court of Protection. There are reasons for believing this would have significant repercussions for the resources of the court, the OS and public authorities alike. The system of welfare hearings in the Court of Protection is already under considerable strain. The OS has repeatedly warned about the growing number of Court of Protection welfare cases he is taking on (Office of the Official Solicitor and the Public Trustee, 2012: [4.2]).<sup>808</sup> The OS recently wrote to the President of the Court of Protection stating that he had reached the limit of his resources with regard to Court of Protection welfare cases,<sup>809</sup> and he would only be able to accept invitations to act in serious medical treatment cases and s21A appeals which were not brought by the person's representative.<sup>810</sup> Even s21A appeal might be subject to a delay in acceptance by the OS until a case manager became available (Official Solicitor, 2012). The number of applications for welfare hearings in the Court of Protection dwarfs the couple of hundred predicted by the impact assessment, although only a small

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<sup>806</sup> See Chapter 5 for a fuller discussion of this. *Shtukaturov v Russia*, [72]-[73]; *X and Y v Croatia*, [84]-[85]

<sup>807</sup> [15]

<sup>808</sup> See Figure 14 in Appendix C for a chart detailing the growing workload of the OS.

<sup>809</sup> The OS later clarified that 'he did not mean by this that he had run out of money, but rather that his available staff, (after movement of staff to this area of work and recruitment to the full extent which was possible), to manage this class of case were unable to take on any more of these cases' (Official Solicitor, 2012).

<sup>810</sup> It is unclear what happens in those cases where a claim is brought under s21A MCA by P's representative if the OS does not act for P. It is possible that the court might substitute P as the claimant, and appoint R to be his litigation friend. Or, it is possible that the proceedings continue with P bound as if a party but not joined as a party. Whilst, in substance, this might not give rise to any material differences in the way the proceedings were conducted, it does seem peculiar that P's appeal should be considered in a case in which he is not represented in his own right.

proportion of these are granted permission (Department for Constitutional Affairs, 2005; Judiciary of England and Wales, 2010; 2011). Even so, the number of health and welfare matters the court decides has increased each year.<sup>811</sup> Senior judges have made comments to the effect that the DoLS and the MCA are having a significant impact on the resource of the Family Division,<sup>812</sup> particularly welfare cases (The Right Honourable Lord Justice (Sir James) Munby, 2011: 34).

The impact on public authorities of an increasing amount of Court of Protection litigation could also be very significant. I conducted a small study, published elsewhere (Series, 2012b), of the costs of DoLS court cases and found that the costs to a local authority alone could range between £4,700 - £58,600, and were typically in the region of £20,000. The average value of a legal aid certificate (for either P or R) was £10,993, and there could potentially be two in a single case. Some cases include health authorities and managing authorities in addition to local authorities, where commissioning arrangements were more complex. If as many people were able to appeal under the DoLS as are currently able to under the MHA, the costs could be astronomical.

In short, the system for hearing welfare disputes in the Court of Protection, which was only ever set up to hear a couple of hundred cases per year, has begun to creak under the strain of even this pitiful trickle of DoLS appeals. It is clear to everyone close to the system that this is not sustainable. In the foreword to the latest edition of his widely read and well respected *Mental Capacity Act Manual* Richard Jones (2012) bemoans judges who have not heeded Hedley J's exhortation that:

...it is absolutely essential that the [court] establishes a practice that... interim cases [concerning the appropriate placement of P] must be dealt with quickly, and, having regard to the demands on the system generally, proportionately, that is to say almost certainly without detailed oral evidence.<sup>813</sup>

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<sup>811</sup> See Table 9 in Appendix C.

<sup>812</sup> In *G v E, A Local Authority & F*, Baker J stated: 'This illustrates a major difficulty which Judges of the Family Division are currently experiencing with cases in this field. The changes brought about by the Mental Capacity Act 2005 have increased the role and work of the Court of Protection. The issues arising in such cases are often extremely complex and require lengthy consideration, but they are also urgent and require speedy determination. The more complex cases are referred to the judges of the Family Division, all of whom are appointed to sit in the Court of Protection. I understand that about ten per cent of the Division's judicial time is at the moment being taken by Court of Protection work, although there has been no corresponding increase in resources. In this case, the court has had to accommodate this overrunning hearing in the middle of other pressing business. Urgent attention needs to be given to increasing the resources of the Family Division to deal with these difficult and urgent cases' [4]. This concern was echoed by the Court of Appeal, *G v E & Ors* [2010] EWCA Civ 822 [75].

<sup>813</sup> *FP v GM and A Health Board* [2011] EWHC 2778 (COP) [12]

Jones cites DJ Eldergill's approach in *A Local Authority v JH*<sup>814</sup>, a judgment which this author at least considered as an excellent example of a careful and considerate approach, as an example of judicial failure to 'focus their attention on the essential issues that arise in applications; the temptation to convert legal proceedings into a Rolls Royce case conference service for the very few should be resisted.' This criticism of the Court of Protection as a 'Rolls Royce case conference service for the few' resonates with much chatter in legal circles. However there is undoubtedly a difficult balance to be struck between the accessibility and efficiency of the court, and its ability to deliver a careful review of complex questions of capacity and best interests, not to mention the manifold technical questions arising out of the Schedules and the meaning of deprivation of liberty. These issues would certainly be exacerbated if there was a greater emphasis on P participating in the process himself, as I have argued in Chapter 5 should be the case. Although it is desirable that the court hears more cases, the danger of hearing more cases in a system not equipped to deal with it is either extensive delays in obtaining justice, or a court which becomes a rubber stamp. It is easy to suggest this in a doctoral thesis, much harder to implement in reality, but it is clear that the problem is that the system itself needs revisiting in its entirety.

There may be many cases where a BIA and others are able to resolve disputes and problems with a detention without resort to a court. However, for the safeguards to function effectively it is imperative that there is a credible threat of litigation should assessors' judgments err, or conditions not be complied with. The court is the keystone which gives the other safeguards their strength and structure. One troubling consequence of this increasing volume of welfare litigation is the temptation for those working within this struggling system to address the problem by limiting the scope of the DoLS themselves, and of detainees' rights of appeal. It is hard to avoid the suspicion that the domestic courts have sought to close down the volume of DoLS-related litigation by significantly narrowing the definition of 'deprivation of liberty' which engages the safeguard. Yet by circumscribing the scope of the DoLS, of court reviews under the DoLS, and the likelihood of compensation for unlawful detention, the court system risks - perhaps unwittingly - significantly diminishing the power of the other safeguards contained within the schedules.

## 6.4 THE MEANING OF DEPRIVATION OF LIBERTY

A shortcoming of the DoLS, which is becoming increasingly apparent, is that Schedule A1 does not apply to all people who might be deprived of their liberty on the

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<sup>814</sup> [2011] EWHC 2420 (COP)



basis that they lack mental capacity, and does not apply in all the settings where they might be detained to. Whereas the MCA applies to anybody over the age of 16, Schedule A1 applies only to over 18's. Schedule A1 applies only in hospitals and care homes, not to other kinds of formal care service.<sup>815</sup> A large number of people with developmental disabilities live in supported living services to which the Schedule does not apply as they are not registered care homes. As described in Chapters 2 and 3, some supported living services may display highly 'institutional' practices, and exercise very high levels of surveillance and control over residents.

Almost a year before Schedule A1 came into force, Munby LJ held in *Salford City Council v GJ & Ors*<sup>816</sup> that a man – BJ – was deprived of his liberty in his accommodation in a supported living service. Finding that the deprivation of liberty could not be authorised under Schedule A1, Munby LJ authorised the detention under the inherent jurisdiction of the court and set out a requirement for (at least) annual court reviews in order to comply with Article 5(4).<sup>817</sup> Laudable though it was to use the common law to provide safeguards for those whom the DoLS did not protect, this decision has presented serious practical problems for the Court of Protection and the Family Division. If large numbers of minors or people accommodated in supported living are, indeed, deprived of their liberty, the courts may very swiftly become swamped by a high volume of authorisations and reviews.

Whilst, of course, it would be illegitimate for the court to allow this to influence their interpretation of the scope of Article 5, it is hard to escape the impression that this has been in the minds of judges in critical cases which have shaped the meaning of 'deprivation of liberty' as it applies in social care settings. There have been three key Court of Appeal rulings on the meaning of deprivation of liberty in the context of incapacity: *P & Q*, *Re RK*, and *Cheshire West and Chester Council v P*. Each of these three cases fell outside the scope of Schedule A1, and – as will be discussed shortly – each of them significantly narrowed the definition of 'deprivation of liberty' as it applies in social care. In each case the High Court or the Court of Appeal appear to have heard pleas from local authorities that if such situations did amount to deprivation of liberty, they – and the courts - would quickly find themselves swamped with the need for court

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<sup>815</sup> The definition of a 'care home' used in Schedule A1 was supplied by the Care Standard Act 2000, which has now been repealed. The Health and Social Care Act 2008 (Consequential Amendments No.2) Order 2010 SI 2010/813 amended the Schedule to incorporate updated definitions of 'hospital' and a definition of the managing authority of a 'care home' as a provider of 'residential accommodation, together with nursing or personal care, in the care home' who is required to register with the CQC (regulation 17).

<sup>816</sup> [2008] EWHC 1097 (Fam)

<sup>817</sup> [36]. Munby LJ was here following the procedure he had established earlier in *Re PS (an adult)* [2007] EWHC 623 (Fam) [23].

applications. Their pleas evoke those of the interveners in the House of Lords in *Bournemouth*:

If the Official Solicitor and the Applicant are right, suggest BCC, the implications will be formidable as a large number of cases will require applications to the Court of Protection by local authorities and further regular consideration in time consuming reviews by both local authorities and the Court of Protection... [T]he Official Solicitor may consider claiming damages on behalf of children who have wrongly been deprived of their liberty. There are therefore out there numerous potential damages claims against a large number of local authorities... BCC therefore argue that this case has considerable implications for local authorities and may have a direct impact on the use of their limited resources available for meeting their responsibilities in respect of vulnerable children.

Mostyn J, in *Re RK*<sup>818</sup>

I entirely ignore the fact that, were this appeal to be allowed, the vast, if unquantifiable, number of necessary reviews of such a character would surely be beyond the present capacity of the Official Solicitor's department and in particular of the Court of Protection. To have an eye to that factor would be to raise to it the wrong end of the telescope. The importance of the right to liberty is paramount (*McKay v. UK* (2006) 44 EHRR 827, at [30]) and the state's positive obligation to provide the facilities necessary for its effective exercise is absolute.

Wilson LJ, in *P & Q*<sup>819</sup>

...the importance of the appeal was not really at all about how P will be dealt with. The point of major importance for the local authority, and indeed local authorities generally, was how often they have to come back to court in this and other like cases.

Munby LJ, in *Cheshire West and Chester Council v P*<sup>820</sup>

These passages suggest that, despite resource implications being an 'irrelevant' factor in the analysis of deprivation of liberty, counsel and courts have devoted considerable energies to reflecting upon them.

Before proceeding to examine the myriad ways in which the courts have attempted to draw a line between those situations which constitute a deprivation of liberty and those which do not, it is worth pausing to reflect on why the DoLS contain these lacunae in respect of supported living. Guardianship, by way of contrast, applies to any setting where a guardian decides a person should live. Twice during the DoLS

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<sup>818</sup> *Re RK*; *YB v BCC* [2010] EWHC 3355 (COP), paragraphs 6-13, see also 44-45.

<sup>819</sup> [5]

<sup>820</sup> [2011] EWCA Civ 1333. NB: this hearing was on costs, the reasoning on deprivation of liberty is contained in [2011] EWCA Civ 1257.

consultations, the CSCI 'made the point ...that deprivation of liberty can occur in social care settings other than care homes, yet people subject to this in other settings would not benefit from the safeguards' (FOIA #22). The British Psychological Society raised similar concerns that community care had expanded beyond care homes in recent decades, and people in other settings should also have access to safeguards (FOIA #21). Age Concern questioned why the safeguards would not apply in Extra Care Housing for older adults (FOIA #21; #22). Despite these loudly, and repeatedly, voiced concerns, uncovered through requests made under the FOIA, they are not mentioned once in the government's consultation response documents (Department of Health, 2006d; Ministry of Justice and Department of Health, 2008b).

To find out why supported living was not covered by the Schedules, I requested from the Department of Health: any research they had relied upon or commissioned when deciding not to extend the DoLS framework to supported living; copies of any documents setting out their reasoning that deprivation of liberty was unlikely to occur in supported living settings and any estimates of the number of people who might be deprived of their liberty in supported living which they obtained or commissioned. The Department initially responded simply that 'The Government did not include supported living because it considered it less likely that severe restrictions would be placed on people in supported living arrangements, who would tend to lead more independent lives'. When pressed to confirm whether such research, documents or statistics were held, the Department of Health responded it neither held, nor knew of, any research on this question, it held no documents which recorded their reasoning that deprivation of liberty was unlikely to occur in supported living and it held no statistical estimates of the number of people who might be deprived of their liberty in supported living. Neither, by 2011, was the Department of Health keeping track of the number of cases of deprivation of liberty in supported living being authorised by the Court of Protection, nor had it considered a revision of the safeguards to extend them to those settings (FOIA #24).

It is extraordinary that the Department of Health and the Ministry of Justice could have failed to even investigate the warnings of such authoritative bodies as the CSCI, the British Psychological Society and Age Concern. This cannot even be pinned to the hurried drafting of the schedules, as these concerns were raised before June 2005<sup>821</sup> and the Bill was not introduced into Parliament until November 2006. The belief that deprivation of liberty simply did not occur in such settings was contradicted by the discovery of the inspectorates that very summer of the abuse of over a hundred adults in supported living services in Cornwall – residents whom the MHAC (2008b: [3.33])

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<sup>821</sup> The Bournemouth Consultation opened in March 2005 and closed in June 2005.

described as *de facto* detained. The Department of Health's belief that all people in supported living services 'would tend to lead more independent lives', and so not require the benefit of statutory Article 5 safeguards, has had disastrous consequences for the DoLS.

#### 6.4.1 KEY ELEMENTS OF DEPRIVATION OF LIBERTY

In *Storck v Germany*<sup>822</sup> the ECtHR distinguished three key elements that engaged Article 5:

1. The *objective element* of confinement in a restricted space for a non-negligible period of time;
2. The *subjective element* of the absence of valid (encompassing capable) consent to that confinement; and
3. *Imputability to the state* whether by way of its active involvement in the detention, or through breach of its positive obligations to provide safeguards for detainees.

In all the cases under discussion here it is common ground that capable consent is absent, and that the state's responsibilities are engaged: thus the debate centres on the interpretation of the *objective* element of Article 5. In *Engel v The Netherlands*<sup>823</sup> the court said 'the starting point must be his concrete situation [and]... account should be taken of a whole range of factors such as the nature, duration, effects and manner of execution of the penalty or measure in question.'<sup>824</sup> In *Guzzardi v Italy*<sup>825</sup> the ECtHR noted that the Convention distinguished between deprivation of liberty under Article 5 and mere restrictions on liberty under Article 2 of Protocol No.8<sup>26</sup> It then added:

The difference between deprivation of and restriction upon liberty is nonetheless merely one of degree or intensity, and not one of nature or substance. Although the process of classification into one or other of these categories sometimes proves to be no easy task in that some borderline cases are a matter of pure opinion<sup>827</sup>

The Guzzardi formulation presents little difficulty for 'paradigm' cases which have long been accepted to represent detention, such as the situation of a prisoner.<sup>828</sup> However, for reasons worthy of an entire discourse analysis in its own right, the status of

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<sup>822</sup> (App no 61603/00) (2005) 43 EHRR 96

<sup>823</sup> (No 1) [1976] 1 EHRR 647 [58][59]

<sup>824</sup> [59]

<sup>825</sup> (App no 7367/76) [1980] 3 EHRR 333

<sup>826</sup> The UK has not ratified this part of the Convention.

<sup>827</sup> [93]

<sup>828</sup> *Secretary of State for the Home Department v JJ & Ors* [2007] UKHL 45; [2007] 3 WLR 642 [37]

those confined to particular social care institutions has remained in the category of 'borderline' cases, matters of 'pure opinion'. *Guzzardi's* emphasis on the concrete situation too easily leads, as Munby LJ put it in *Cheshire* 'to the worrying and ultimately stultifying conclusion that the decision in every case can safely be arrived at only after a minute examination of all the facts in enormous detail.'<sup>829</sup> Meanwhile the necessity of drawing line across the gradations between restrictions of liberty and deprivation of liberty calls to mind the Sorites paradox,<sup>830</sup> well known to philosophers. Doctrinal lawyers, as Clements (2011: 682) has noted, 'crave the "discrete incident"', and so it is that Munby LJ and others have sought to identify that elusive element 'which enables us to pursue a more focussed and less time-consuming enquiry' and evade the Sorites paradox.<sup>831</sup> Unhappily, each judge appears to have happened upon a unique element of their own, which often appear to contradict the *ratio* of other cases or be difficult to apply in cases with different facts. In what follows I review the trajectory of some such elements from *Bournemouth* through the domestic case law, and consider how the recent trinity of ECtHR rulings on deprivation of liberty in social care might impinge upon domestic interpretations.

#### CONTINUOUS SUPERVISION AND CONTROL AND FREEDOM TO LEAVE

The *ratio* for the ECtHR finding that HL was deprived of his liberty in Bournemouth Hospital was initially understood by many to be that 'the concrete situation was that the applicant was under continuous supervision and control and was not free to leave.'<sup>832</sup> However, even at the time HL's own legal team noted that 'The paradox is that if this is what the ECtHR meant by deprivation of liberty then, because of the nature of his condition, it is difficult to envisage circumstances in which HL is free' (Robinson and Scott-Moncrieff, 2005: 22). A similar point was made by Jackson J in *Neary*, commenting that Steven Neary 'is to some degree or other necessarily subject' to deprivation of liberty 'wherever he lives'.<sup>833</sup> A construction of deprivation of liberty as not being free to leave a place because one is subject to the control of others could potentially apply to very large numbers of people indeed who are said to lack the mental

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<sup>829</sup> [38]

<sup>830</sup> The Sorites paradox is also known as the 'paradox of the heap' which arise from 'little by little arguments' where the boundaries around a particular predicate are vaguely defined. In the classical formulation, 'no one grain of wheat can be identified as making the difference between being a heap and not being a heap. Given then that one grain of wheat does not make a heap, it would seem to follow that two do not, thus three do not, and so on. In the end it would appear that no amount of wheat can make a heap. We are faced with paradox since from apparently true premises by seemingly uncontroversial reasoning we arrive at an apparently false conclusion' (Hyde, 2011).

<sup>831</sup> *Cheshire*, [39]

<sup>832</sup> *HL v UK*, [91]

<sup>833</sup> *Neary*, [151]

capacity to decide where they live. Freedom of egress for such people would, in most cases, be subject to the permission of some substitute decision maker. For those who would seek to limit the scope of the DoLS, this is a very unattractive outcome indeed, especially since - as Robinson and Scott-Moncrieff noted – a strict reading of it could potentially even include people being cared for by their family.

In the early case of *JE v DE & Ors* Munby J himself seemed to take such an expansive reading of ‘freedom to leave’ when he found that Mr DE was deprived of his liberty by not being permitted to leave the care home where he was accommodated to return home to live with his wife. The local authority protested that Mr DE was not subject to the same level of controls as Mr HL, that he enjoyed considerable freedoms within the care home and was given support to go on visits to other place. However, Munby LJ retorted that for the purposes of Article 5 freedom to leave did not mean ‘for the purpose of some trip or outing approved by [the Council] or by those managing the institution; I mean leaving in the sense of removing himself permanently in order to live where and with whom he chooses.’<sup>834</sup> Robinson (2007) noted that Munby J’s definition in *JE v DE* would encompass far greater numbers of people than those anticipated by the DoLS impact assessment, and other eminent lawyers lamented that it seemed to go beyond Strasbourg’s ruling in *HL v UK* (Morris, F., and Ruck Keene, 2007).<sup>835</sup>

This expansive reading of deprivation of liberty did not withstand the test of time. In the first instance hearing of *P & Q*, a case then known as *Surrey County Council v MEG & MIG v Anor*, it was suggested by the OS that two young women with learning disabilities aged 17 and 18 might be deprived of their liberty by placements in a foster care home (for MIG, or P) and a small group home (for MEG, or Q). Parker J noted that ‘If either wished to leave in the immediate sense each would be restrained or brought back for their safety’<sup>836</sup> yet found that neither were deprived of their liberty. Equating deprivation of liberty with lacking the freedom to leave the place where one is living, in Parker J’s view, ‘casts the net too wide’.<sup>837</sup> Freedom to leave had to be assessed against the background that neither wanted to leave, nor was there any alternative home.<sup>838</sup> By the time MIG and MEG arrived in the Court of Appeal as *P & Q* other issues more closely connected with purpose, normality and objections were the focus of the appellate courts’ attentions and ‘freedom to leave’ was not even discussed as a relevant factor. A recent High Court ruling gave a striking example of the burial of ‘freedom to

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<sup>834</sup> [115]

<sup>835</sup> This concern was taken up by Angela Browning MP in Parliament to press the government on whether further resources would be required than they had anticipated. The government did not respond to this particular point. *Hansard* HL vol 460 col 392-6 (15 May 2007)

<sup>836</sup> [233]

<sup>837</sup> [223]

<sup>838</sup> [225]

leave' for Article 5 purposes. In *C v Blackburn and Darwen Borough Council* Jackson J found that a man who was subject to 1:1 supervision within and outside his care home, who lived there on the basis of a decision of his guardian, who objected strongly to living there and had kicked down a door trying to escape it, was not deprived of his liberty *because he had nowhere else to go*.

The second element of the *ratio* in *HL v UK* – being subject to 'continuous supervision and control' – was also dismissed by Parker J in *MIG & MEG*, saying that:

Each lacks freedom and autonomy dictated by their own disability, rather than because it is imposed on them by their carers. Each is under the continuous supervision and control of her carers ...so as to meet her care needs rather than to restrain her in any way.<sup>839</sup>

This contained the seed of two related tactics to mitigate what would otherwise be a deprivation of liberty: reliance on the *purpose* of restrictions and locating the loss of liberty in the individual's impairment, rather than a social response to it. Although, in general, being subject to continuous supervision and control no longer equates to being deprived of one's liberty in the domestic case law, this element of control seems to have continued to be influential in cases concerning the prevention of sex. In *D Borough Council v AB* and *A Local Authority v H* both AB and H were said to be deprived of their liberty because they were subject to restrictive care regimes for the purpose of preventing them from having sex. Neither judgment considers why these regimes constituted deprivation of liberty as this was not a contested point, so it is uncertain how exactly they fit into the Article 5 landscape after *P & Q*.

Parker J's decision in *MIG & MEG* appeared to be the last sighting of 'freedom to leave' for domestic purposes; it very rarely appeared in the published cases which followed.<sup>840</sup> Meanwhile, the three recent rulings on deprivation of liberty in care facilities from Strasbourg all appear to have applied criteria remarkably similar to the early supposed *ratio* in *HL v UK*. In *Stanev, DD* and *Kędzior* the *ratio* for finding the claimants were deprived of their liberty was almost identical to that given in *HL v UK* – that they were under continuous supervision and control, and were not free to leave.<sup>841</sup> In each case the defendant governments argued that the claimants were free to leave the institutions to make visits or trips, but the ECtHR emphasised that this was always subject to the permission of management.<sup>842</sup> The *ratio* in these ECtHR authorities

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<sup>839</sup> [233]

<sup>840</sup> *C v A Local Authority*, where C was not only confined to the school but also – frequently – to a seclusion room, is a rare example of a lack of 'freedom to leave' contributing towards a finding of deprivation of liberty [48].

<sup>841</sup> *Stanev* [128]; *DD* [146]; *Kędzior* [57]

<sup>842</sup> *Stanev* [124], [128]; *DD* [146]; *Kędzior* [57]

echoes a definition of deprivation of liberty found in the UN Optional Protocol on the Convention against Torture ('OPCAT', United Nations, 2006b), which defines deprivation of liberty as 'the placement of a person in a public or private custodial setting which that person is not permitted to leave at will by order of any judicial, administrative or other authority.'<sup>843</sup> The Human Rights Implementation Centre (HRIC, 2011) has commented that in some states there have been disagreements as to whether care homes could fall under the umbrella of OPCAT.<sup>844</sup> However, the HRIC observes that Article 4 'covers both 'traditional places of detention' such as prisons and police cells as well as less traditional ones such as, but not limited to, social care homes, psychiatric hospitals and centres for children' (HRIC, 2011: 3). Although domestic case law resists that identification, internationally there appears to be growing recognition that social care homes may be places of detention where a person's egress is subject to the control of the authorities.

#### OBJECTIONS, ESCAPE ATTEMPTS AND HAVING SOMEWHERE ELSE TO GO.

In *Storck* the ECtHR distinguished between the 'objective' and 'subjective' elements of deprivation of liberty, with objections and the absence of capable consent falling into the latter category. In *HL v UK*, HL was found to be deprived of his liberty despite not resisting or objecting to his admission to hospital, and not attempting to escape. Nevertheless, in domestic case law the 'subjective' element has increasingly bled into the 'objective' element and increasing weight has been placed on a person's objections to their confinement.

In *MIG & MEG*, Parker J stated that 'Notwithstanding that MIG and MEG cannot consent to their placements, the fact of happiness in their respective environments, each regarding the place where they live as home, and their wish to stay there, must be relevant to the question of both the objective and the subjective element.'<sup>845</sup> In the Court of Appeal, Wilson LJ rejected Parker J's analysis that happiness was relevant to the 'objective element' of deprivation of liberty,<sup>846</sup> but found that the 'overlapping feature' of whether or not a person *objects* to the confinement which is imposed on her 'is relevant to the enquiry.'<sup>847</sup> However, objections per se do not appear to be the defining feature of

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<sup>843</sup> Article 4(2) OPCAT

<sup>844</sup> According to HRIC this was connected with a Russian translation of OPCAT Article 4 as 'содержания под стражей', meaning 'holding someone under (armed) guard'. HRIC comment 'This poses a challenge especially in the post-Soviet countries many of whom have inherited the Soviet system of criminal justice where this term was used only to refer to imprisonment and police custody and therefore excluded such forms of deprivation of liberty as placement in social care homes or orphanages.'

<sup>845</sup> [204]

<sup>846</sup> [24]

<sup>847</sup> *P & Q*, [25]



Wilson LJ's analysis, rather objections are relevant because overruled objections inherently give rise to a 'level of conflict'. Meanwhile, according to Wilson LJ, 'the absence of objections generates an absence of conflict and thus a peaceful life, which seems to me to be capable of substantial relevance in the opposite direction.'<sup>848</sup> Wilson LJ also held that 'in that objections may be highly relevant, medication which has the effect of suppressing them may be relevant to an equally high degree. But again, conversely, the absence of medication is a pointer in the other direction.'<sup>849</sup> Curiously, Wilson LJ did not discuss whether Q's (MEG) being administered the potent and sedating anti-psychotic risperidone might be suppressing any potential objections of hers.

Objections were not specifically discussed by Munby LJ in *Cheshire*, although he did indicate that 'where a person has somewhere else to go and wants to live there but is prevented from doing so by a coercive exercise of public authority' he is more likely to be deprived of his liberty.<sup>850</sup> It must be that *wanting* to live elsewhere is a key factor, as in several other cases where people have had somewhere else to go but expressed no desire to live there they have not been found to be deprived of their liberty.<sup>851</sup> Conversely, wishing to be 'elsewhere' but having nowhere else to go seems not to amount to a deprivation of liberty in the domestic cases. In *C v Blackburn and Darwen Borough Council*, C's clear objections and physical escape attempts were not taken to be indicators that he was deprived of his liberty because 'He would like to be able to live an unconfined life in the community, but this is not realistically possible due to the extent of his difficulties'.<sup>852</sup> Jackson J distinguished C's 'situation from those where a person has been removed from a home that is still realistically available.'<sup>853</sup> Oddly, Jackson J never discussed the significance given to objections and conflict by Wilson LJ in *P & Q*, but instead relied entirely upon Munby LJ's emphasis in *Cheshire* of those cases where a person not only wants to go and live elsewhere but has somewhere else to go.

Two other cases appeared to go even further than *C v Blackburn and Darwen* and are difficult to reconcile to either *Cheshire* or *P & Q*. In the background to the case *Re RK* was a dispute between RK's parents and the local authority 'as to whether it should fund care package that the parents believe is necessary in order to bring RK

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<sup>848</sup> *P & Q*, [25]

<sup>849</sup> *P & Q*, [26]

<sup>850</sup> [58]

<sup>851</sup> See: *LLBC v TG* and *Re MP, LBH v GP*.

<sup>852</sup> [26]

<sup>853</sup> [26]

home'.<sup>854</sup> RK herself was said to be 'very upset in her current placement and is not eating'.<sup>855</sup> One might have thought this satisfied both the objections element of deprivation of liberty, and the existence of an alternative placement, yet the court did not discuss either element of this analysis of deprivation of liberty. It might be argued that the existence of an alternative home was not 'realistically available' because of the refusal of the local authority to provide an adequate package of care. Yet this places a remarkable amount of power in the hands of public authorities to determine the scope of Article 5 through the application of their public law discretionary powers.

In *CC v KK*, KK expressed 'a strong wish to return home'<sup>856</sup>, had brought a s21A MCA appeal on that basis, and had an alternative home – a bungalow – to go to. This would appear to be precisely the circumstances Munby LJ in *Cheshire* considered would still amount to a deprivation of liberty, where 'a person has been removed from a home that is still realistically available.'<sup>857</sup> Nevertheless, Baker J found that KK was not deprived of her liberty because 'there is now little evidence that her overruled objections lead to a significant degree of conflict'<sup>858</sup>, 'the arrangements for her care could not, in my view, be described as one of "continuous control".'<sup>859</sup> and because 'Considerable time and effort is devoted to enabling KK to experience a greater degree of freedom' through visits to her home.<sup>860</sup> There is very little consistency of approach in these cases as to which elements should be determinative and in what combinations and permutations.

In the three most recent Strasbourg cases of *Stanev, DD* and *Kędzior*, the claimants were all clearly objecting to their confinement in social care facilities. There are no indications from the judgments that this gave rise to a more significant degree of conflict than that described in *CC v KK*. In the cases of *Stanev* and *DD* there was no suggestion that either claimant had somewhere else which they could go to if they left the facility. In *Stanev* and *Kędzior* the absence of alternatives to confinement in social care institutions was a specific matter of concern raised by the interveners (Cojocariu and Duffy, 2010; Mental Disability Advocacy Center, 2009). In *HL v UK*, of course, HL himself was not objecting – and there is no obvious reason why the absence of objections should carry any less weight in a care facility than a hospital.

These ECtHR cases suggest that the domestic courts have taken a wrong turn in trying to interpret deprivation of liberty. It is very difficult to see how a person in HL's situation, had he not had carers demanding his release, would have brought his

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<sup>854</sup> [2010] EWHC 3355 (COP) [34]

<sup>855</sup> *Re RK; RK v BCC* [2011] EWCA Civ 1305 [2]

<sup>856</sup> [7]

<sup>857</sup> [26]

<sup>858</sup> [99]

<sup>859</sup> [100]

<sup>860</sup> [102]

predicament to the attention of anybody in authority. Neither do cases like *C v A Local Authority*, where very serious shortcoming in the care of a young man with autism were exposed in connection with deprivation of liberty proceedings in the Court of Protection, fit easily into the schema adopted by the domestic courts. C's family were not offering him an alternative placement, and distressed though he was he was not said to be 'objecting' to his placement any more than HL was. The consequences of excluding situations where a person has nowhere else to go, or is not vociferously objecting, are likely to be serious for a population who are often reliant upon the state to provide alternative placements, who may have significant communication impairments, be heavily institutionalised or merely be cowed by those in authority.

### RESTRICTIONS AND PURPOSE

In *Guzzardi* the court held that 'The difference between deprivation of and restriction upon liberty is nonetheless merely one of degree or intensity, and not one of nature or substance.'<sup>861</sup> Nevertheless, the domestic courts have attempted to distinguish deprivation of liberty from mere restrictions on liberty on substantive grounds connected with the purpose of those restrictions. Although there have been some cases where people who are subject to high levels of restrictions on their liberty have been found to be deprived of their liberty,<sup>862</sup> the general direction of travel in domestic case law has been to divorce the concept of 'detention' from even very intensive restrictions.

In *MIG & MEG* both MIG and MEG were subject to continuous supervision and control and MEG (Q) in particular was subject to physical restraint and the administration of medications to control her mood. Parker J's analysis of the relevance of these restrictions to the question of whether or not MIG or MEG were deprived of their liberty owed a great deal to the House of Lords' ruling in *Austin & Anor v Commissioner of Police of the Metropolis*.<sup>863</sup> In *Austin* the Lords found that protesters who were 'kettled' by a police cordon during protests were not deprived of their liberty. Lord Hope held that 'there is room, even in the case of fundamental rights as to whose application no restriction or limitation is permitted by the Convention, for a pragmatic approach to be taken which takes full account of all the circumstances' including the purpose of such restrictions.<sup>864</sup> Parker J claimed to 'treat with extreme caution the suggestion that purpose is relevant' to whether or not a person is objectively deprived of their liberty, and she agreed that it was 'impermissible' to consider whether confinement 'is with good or

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<sup>861</sup> [93]

<sup>862</sup> E.g. *HL v UK, D Borough Council v AB, A Local Authority v H, and C v A Local Authority*.

<sup>863</sup> [2009] UKHL 5; [2009] 1 AC 564

<sup>864</sup> [34]. See also the comments of Lord Scott [39], Lord Neuberger [57], [60] and the concurring but cautious remarks of Lord Walker [43]-[47].

benign intentions or in their best interests'.<sup>865</sup> However, she did find that it is relevant to 'consider the reasons why they are under continuous supervision and control'.<sup>866</sup> In this case, control was exercised over the two girls 'so as to meet her care needs rather than to restrain her in any way'.<sup>867</sup> The purpose of restraint was for 'ensuring safety' and for MEG 'for her immediate protection and that of others when she has an outburst'.<sup>868</sup> MEG's tranquilising medication was 'not administered to MEG so as to restrain her from leaving or to restrain her activities generally',<sup>869</sup> but 'for the purpose of controlling her anxiety'.<sup>870</sup> Consequently, she held, the restrictions they were subject to did not amount to deprivation of liberty. It is difficult to understand quite how Parker J's reasoning that these restrictions did not amount to a deprivation of liberty did not turn on the prohibited basis of their good or benign purpose.

The appellate courts have taken a rather ambiguous approach to Parker J's use of purpose as derived from *Austin*. In *P & Q Wilson* LJ said 'To the extent that... the judge was there attaching significance to the fact that the purpose of the arrangements for the girls was to further their best interests, I believe that she was wrong to do so'<sup>871</sup> and went on to set out an alternate principle of normality, discussed below. Earlier rulings by Munby LJ also appeared to strongly reject this approach, saying in *JE v DE*:

The argument, if taken to its logical conclusion, would seem to lead to the absurd conclusion that a lunatic locked up indefinitely for his own good is not being deprived of his liberty. And if beneficent purpose cannot deprive what is manifestly a deprivation of liberty of its character as such, why should a beneficent purpose be of assistance in determining whether some more marginal state of affairs does or does not amount to a deprivation of liberty?<sup>872</sup>

However, Munby LJ appeared to resurrect this use of purpose in *Cheshire*<sup>873</sup> where he stated:

...it is legitimate, in my judgment, in determining whether or not there is a deprivation of liberty, to have regard both to the objective 'reason why

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<sup>865</sup> [230]

<sup>866</sup> [164]

<sup>867</sup> [233]

<sup>868</sup> [233]

<sup>869</sup> [233]

<sup>870</sup> [216]

<sup>871</sup> [27]

<sup>872</sup> [47]

<sup>873</sup> In fact Munby LJ had already discussed purpose in the High Court shortly after the ruling in *MIG & MEG*, but before the appeal court ruling in *P & Q*, in *A Local Authority v A (A Child) & Anor*. Here he commented on the one hand that 'one must be careful not to put undue emphasis upon such matters as purpose and intention' [126] but then went on to find that the fact that 'A is not confined for the purposes of punishment but to safeguard her welfare' [154] was a 'powerful submission' [155] pointing away from their being any deprivation of liberty.

someone is placed and treated as they are and also to the objective 'purpose' (or 'aim') of the placement.<sup>874</sup>

An improper motive or intention, he said, 'may have the effect that what would otherwise not be is in fact, and for that very reason, a deprivation of liberty', however a good intention or motive 'cannot render innocuous what would otherwise be a deprivation of liberty'.<sup>875</sup>

The reasoning in *Austin*, and its corollaries in *MIG & MEG* and *Cheshire*, has been subject to extensive criticism by legal scholars and practitioners. Feldman (2009: 244) agrees that a custodian's intentions might mean that a situation becomes a deprivation of liberty, where his intention is to prevent a person from leaving,<sup>876</sup> but argues that his purpose 'is relevant only to whether a deprivation of liberty can be justified' not whether it is occurring at all. There is no dispute, in these cases, that the custodians intend to prevent their charges from leaving. Mead (2009: 392) cautioned that *Austin* would make Article 5 'increasingly redundant' for the purpose of requiring states to justify detention, by 'defining out' arrests and detentions by reference to states of mind. Mead is also highly critical of the idea that detention is not a deprivation of liberty if its purpose is to benefit the detainee, saying this 'smacks of benevolent authoritarianism which most would consider to be inimical to a system of human rights premised on individuality, on autonomy and on dignity' (p390).

On Munby LJ's use of *Austin* in *Cheshire*, Hewitt (2012) complains that the 'idea surely takes us back once again ...to the days before the *Bournemouth* case' and that the 'possibility that good intentions will prevent there being deprivation of liberty flatly contradicts the decision in that case.' Given that deprivation of liberty can only be authorised under the MCA if it is necessary and in a person's best interests, it is difficult to reconcile the ruling in *Cheshire* to the very purpose of the safeguards. Hewitt comments that 'the DoLS are relevant where an incapable person is deprived of liberty in his own best interests; yet, if strict observation of best interests will prevent there being deprivation of liberty, there will be no patient to whom the DoLS apply.' Troke (2012: 59) makes the point that it becomes:

...difficult to imagine a situation that would be a deprivation that could still be lawful (whether by DOLS authorisation or by Court of Protection order) as being in P's best interests, necessary and proportionate, and the least restrictive option. It would seem that *Cheshire* suggests all the conditions that are required to make any deprivation lawful will, in effect, mean in most cases that there is no deprivation at all.

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<sup>874</sup> *Cheshire*, [76]

<sup>875</sup> *Cheshire*, [76]

<sup>876</sup> Feldman cites *HL v UK* in support of this proposition.

Since the rulings in *MIG & MEG* and *Cheshire*, *Austin* has been heard by the ECtHR.<sup>877</sup> The Strasbourg court resoundingly rejected the analysis of the House of Lords, stating that ‘...the purpose behind the measure in question is not mentioned in the above judgments as a factor to be taken into account when deciding whether there has been a deprivation of liberty.’<sup>878</sup> However the court did find that Article 5(4) should be ‘interpreted in a manner which takes into account the specific context in which the techniques are deployed’.<sup>879</sup> It agreed that in a context where ‘the police had no alternative but to impose an absolute cordon if they were to avert a real risk of serious injury or damage’<sup>880</sup> that it did not constitute a deprivation of liberty.

On the face of things, the ECtHR appears to have employed the same sleight of hand as the domestic courts, on the one hand denying that the purpose of restrictions is relevant to whether or not a deprivation of liberty has occurred, and then appearing to bring purpose back in through a broadly synonymous concept. However, the authors of the 39 Essex St Court of Protection Newsletter argue that the reasoning in *Austin v UK* can be distinguished from the use of purpose in *Cheshire* and elsewhere because:

There is no concern that by finding that P was deprived of his liberty in the *Cheshire* case, it would be impracticable for local authorities to fulfil their duties in providing community care, because, unlike in *Austin*, where the acts of the police did not fall within one of the exhaustive categories in Article 5 and therefore could not be justified if Article 5 was engaged, the deprivation of P’s liberty could be warranted as being proportionate and in P’s best interests.<sup>881</sup>

Speaking extra-curially, Munby LJ has suggested that following the ECtHR’s ruling in *Austin v UK*, the ‘questions of reason, purpose, aim, motive and intention are wholly irrelevant to the question of whether there is a deprivation of liberty’ and that *Cheshire* may need to be reconsidered in light of this (Lord Justice Munby, 2012a: 35). However, an even more recent ECtHR ruling in *Munjaz v United Kingdom*<sup>882</sup> found that secluding a detained mental health patient did not constitute any additional deprivation of his residual liberty by reference to the aims of the seclusion, and the fact that it was not imposed as a punishment.<sup>883</sup>

Consequently, the relevance of the purpose, aims, motive or reasons for restrictions on liberty to the question of whether or not a person is deprived of their liberty, and hence eligible for safeguards, is highly uncertain. The difficulty with tying the

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<sup>877</sup> *Austin and Others v United Kingdom* (App no 39692/09) [2012] ECHR 459

<sup>878</sup> [58]

<sup>879</sup> [60]

<sup>880</sup> [66]

<sup>881</sup> Ruck Keene et al (2012c: 3)

<sup>882</sup> (App no 2913/06) [2012] ECHR 1704

<sup>883</sup> [70]

definition of deprivation of liberty to the justification for restrictions is that it seems to short-circuit the use of deprivation of liberty safeguards to ensure that restrictions are, indeed, so justified. As Troke and Hewitt observe, for so long as beneficent purpose means that restrictions on liberty do not qualify for safeguards under the DoLS, it is extremely difficult to see how a person's care could both constitute a deprivation of liberty and be lawful under the MCA and the DoLS. It should be recalled that the facts of *Stanev, DD* and *Kędzior* are much closer to the facts of deprivation of liberty in social care settings than *Munjaz* and noted that they make little or no<sup>884</sup> reference to the purpose of restrictions in finding deprivation of liberty to be occurring.

### NORMALITY AND COMPARATORS

The 'normality' of a person's living arrangements has also been used by the courts to distinguish circumstances which amount to a deprivation of liberty from those which do not. Normality made an early appearance in *LLBC v TG*, where living in 'an ordinary care home where only ordinary restrictions of liberty applied' carried weight for MacFarlane J in finding that TG was not deprived of his liberty.<sup>885</sup> Subsequently, the 'normality' of a person's living arrangements was adopted by the Court of Appeal in *P & Q* as one of two key considerations (the other being objections) in determining whether or not a person was deprived of their liberty. Wilson LJ stated:

If the person is living with her parents or other members of his natural family in their home, she is living – in that respect – the most normal life possible. Typically – but sadly not always – there will be no deprivation of liberty in such circumstances:... Not much less normal for this purpose is the life of a child in the home of foster parents or of an adult... But, even when the person lives in an institution rather than in a family home, there is a wide spectrum between the small children's home or nursing home, on the one hand, and a hospital designed for compulsory detentions like Bournemouth; and it is in my view necessary to place each case along it.<sup>886</sup>

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<sup>884</sup> In *Stanev* the Bulgarian government argued that the state had been obliged to bring Mr Stanev back to the care home in accordance with its positive obligations to protect care home residents from harm, as found in *Dodov v Bulgaria*. The ECtHR in *Stanev* countered that in *Dodov* 'the applicant's mother suffered from Alzheimer's disease and that, as a result, her memory and other mental capacities had progressively deteriorated, to the extent that the nursing home staff had been instructed not to leave her unattended. In the present case, however, the Government have not shown that the applicant's state of health was such as to put him at immediate risk, or to require the imposition of any special restrictions to protect his life and limb' [128]. This passage rather unhelpfully suggests – without actually going so far as to explicitly say it – that the ECtHR might not be inclined to find deprivation of liberty is occurring if restrictions are imposed to protect life and limb. However, this issue is not discussed any further, the case of *Dodov* was not a case concerning Article 5, so it would be a very weak authority in the face of *Austin* for maintaining that restrictions for the preservation of life and limb could never be a deprivation of liberty.

<sup>885</sup> [105]

<sup>886</sup> [28]

Wilson LJ went on to say that the ‘enquiry into normality transcends an enquiry into the residential arrangements’ and should also have regard to whether or not a person attends school, college a day centre or other occupation.<sup>887</sup> This reasoning appeared to influence Baker J in finding that KK was not deprived of her liberty in *CC v KK*, as she was able to make regular visits home and the care home was ‘an ordinary care home where only ordinary restrictions of liberty apply’.<sup>888</sup>

It might be countered that for the man on the Clapham Omnibus, living under the restrictions that *MIG and MEG*, KK and others were subject to in their care homes would not be altogether ‘normal’. However, in *Cheshire* Munby LJ further refined the normality principle by introducing the concept of ‘relative normality’ and the ‘comparator approach’. In the first instance hearing of *Cheshire*<sup>889</sup>, Baker J had found that P was deprived of his liberty even though the local authority had taken great care to ensure P’s life was as normal as possible. He did not live in accommodation designed for compulsory detention,<sup>890</sup> he had regular contact with his family, attended a day centre five days a week and had a good social life with staff and other residents.<sup>891</sup> However, for Baker J this did not mitigate the fact that ‘his life is completely under the control of members of staff at Z House’, and a range of measures including physical restraint had to be adopted by staff to stop him from attempting to ingest his soiled incontinence pads, which presented a serious risk of choking.<sup>892</sup> According to Munby LJ in the Court of Appeal, Baker J had erred in his analysis because he had not compared ‘P’s situation in the Z House with the kind of life P would have been leading as someone with his disabilities and difficulties in what for such a person would be a normal family setting’.<sup>893</sup> He had not, according to Munby LJ, ‘grappled with the question whether the limitations and restrictions on P’s life at Z House are anything more than the inevitable corollary of his various disabilities’.<sup>894</sup>

Relying on a manoeuvre used by the ECtHR in *Engel v The Netherlands*, Munby LJ argued that the analysis of whether or not a person was deprived of their liberty depended upon the life they would have been living otherwise.<sup>895</sup> In order to assess ‘relative normality’ of restrictions, it was necessary to find the appropriate ‘comparator’:

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<sup>887</sup> [29]

<sup>888</sup> *CC v KK*, [101]

<sup>889</sup> *Cheshire West and Chester Council v P & Anor* [2011] EWHC 1330 (Fam)

<sup>890</sup> P lived in supported living accommodation.

<sup>891</sup> [58]

<sup>892</sup> [59]

<sup>893</sup> [110]

<sup>894</sup> [110]

<sup>895</sup> See paragraphs 97-82 of the Court of Appeal in *Cheshire*.



...when evaluating and assessing the 'relative normality' (or otherwise) of X's concrete situation in a case such as this, the contrast is not with the previous life led by X (nor with some future life that X might lead), nor with the life of the able-bodied man or woman on the Clapham omnibus, but with the kind of lives that people like X would normally expect to lead. The comparator, in other words, is an adult of similar age with the same capabilities as X, affected by the same condition or suffering the same inherent mental and physical disabilities and limitations (call them what you will) as X. Likewise, in the case of a child the comparator is a child of the same age and development as X.<sup>896</sup>

The 'comparator' approach embodied by *Cheshire* has been subject to a range of criticisms, and will eventually fall to be considered by the Supreme Court.

In Hewitt's (2012) critique of *Cheshire* and *P & Q* he cites a passage from the autobiography of Jaycee Dugard, describing watching fireworks on the roof of a barn with a man who is, it transpires, her kidnapper.<sup>897</sup> Hewitt states that normality is a 'decidedly dubious notion' and cautions that 'life can look very different from the outside.' It should hardly need saying that approaches to the care of people with disabilities can appear 'normal' in a given place and time, yet appear abhorrent with hindsight.<sup>898</sup> In a national conference the OS, Alastair Pitblado, was reported to say that 'people in care homes, if they are nice care homes and there are red roses around the front door and not many residents or rooms' had very limited protection as they were no longer considered to be deprived of their liberty (Samuel, 2012b).

This use of 'normality', particularly as it appears in *P & Q*, seems to rest upon a judicial fantasy of institutional care services being, in the main, delightful places to live where residents need only minimal protection to ensure their rights are protected. It is extremely difficult to reconcile this fantasy with the reality repeatedly uncovered by national audits of care services which found them to be places prone to excessive and inappropriate restrictive care, where there was reason to believe that people's rights were routinely being violated (Banerjee, 2009; Care Quality Commission, 2009a; 2012b; f; g; Commission for Social Care Inspection, 2007; Healthcare Commission, 2007b; Royal College of Physicians and British Society of Gastroenterology, 2010).

The comparator approach also seems to be discriminatory in a number of respects. Baker J comments that a difficulty with *Cheshire* may be that 'it may permit

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<sup>896</sup> *Cheshire*, [97]

<sup>897</sup> Jaycee Dugard was abducted at the age of 11 in the US state of California, and was not found for eighteen years. Although Dugard was initially kept in close captivity by her kidnapper, Phillip Garrido, eventually he allowed her and the daughters she bore him to come into contact with members of the public, but she never told them she had been abducted nor attempted to leave. Only after Garrido confessed to abducting Dugard to police did she reveal her true identity to them.

<sup>898</sup> For example, some states still routinely use caged beds for children with disabilities ('Filming reveals Czech children still caged', 2008)

some people to be denied a declaration of deprivation of liberty in circumstances where others would be entitled to such a declaration'.<sup>899</sup> By finding that restrictions which are 'necessary' because of a person's disability do not amount to a deprivation of liberty, the ruling seems to mean that the more restrictions a person is taken to need because of their disability, the greater the interferences they may be subject to before the law offers them an accessible means to challenge those restrictions. Ironically, this means that those with the most significant (perceived) difficulties in making decisions around risk and protecting themselves may benefit the least from the safeguards (Series, 2011b). Mind (2012) has expressed concern that the ruling in *Cheshire* will make it harder for 'vulnerable people' to challenge and request regular reviews of significant restrictions on their liberty, in contrast with those detained under the MHA. Troke (2012: 59) highlights that those 'who do not have family offering alternative proposals', and so are not considered deprived of their liberty by way of having an alternative residence, will be left especially vulnerable by the ruling in *Cheshire* as there will be little ongoing scrutiny of their care. In an awful irony, the comparator approach means that the unbefriended will be the least entitled to this extra source of scrutiny of their care.

It would seem from Munby LJ's comments in *Cheshire* and elsewhere (Lord Justice Munby, 2012a: 34) that he hoped this 'comparator' approach had clarified the meaning of deprivation of liberty, and would give rise to a more 'a more focussed and less time-consuming enquiry' than a 'minute' examination of the restrictions a person was subject to.<sup>900</sup> There are reasons to doubt that *Cheshire* can live up to this hope. As solicitor John O'Donnell (2012) puts it, 'It would lead to a case by case examination as to whether or not particular disabilities were sufficiently similar to establish the comparison'. O'Donnell anticipates considerable evidential issues and scope for legal argument arising on this point. The comparator approach rests on two connected assumptions: that it is straightforward to identify a person 'with the same capabilities as X, affected by the same condition or suffering the same inherent mental and physical disabilities and limitations ...as X', and that it is a straightforward matter to describe what restrictions they should be subject to.

From the outset, reflection on the social model of disability should caution us that it is never easy to divorce a person's 'disabilities' from their context, as the comparator approach would seem to have us do. For example, a person might be subject to high levels of restrictions in a setting which they are unhappy in and trying to escape from, whilst they need not be if they were in a setting where they are happy and content. A person who is frequently restrained to protect themselves or others from harm may

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<sup>899</sup> *CC v KK*, [92]

<sup>900</sup> [38]-[40]

manifest this 'behaviour that challenges' because they are unhappy, because they have unmet care needs or for other context-specific reasons. This medicalisation and individualisation of restrictions averts our attention from the fact that restrictions on liberty are perpetrated by staff, who exercise considerable discretion and power in this respect. Without the DoLS, there are few mechanisms to call those exercising this control to account for it. The rulings in *P & Q* and *Cheshire* perpetuate the notion that people with disabilities are inherently and intrinsically 'other' than the man on the Clapham Omnibus. As Hewitt (2012) puts it, 'it seems to abandon the idea that there are common standards – common liberties, we might say, or common protections – that are available to everyone; and it implies that the mentally ill or the mentally incapable are entitled to fewer protections, to lower-grade liberty.'

The comparator approach also seems suffer from the same deficiency as the 'purpose' of restrictions. In order for restrictions to satisfy s6 MCA, they must be 'necessary', and that necessity must arise in connection with a person's lack of mental capacity to make decisions about a particular risk. Yet the comparator holds that if restrictions are necessary because of a person's disability, which they must be if they are justified under the MCA, then they are unlikely to contribute towards a deprivation of liberty. It is very difficult to see how a person could both be said to be deprived of their liberty and the restrictions be compatible with the MCA and the DoLS (Hewitt, 2012; O'Brien, 2012; Series, 2011b; Troke, 2012).

Nothing resembling the comparator approach has been invoked by the ECtHR in *Stanev, DD or Kędzior* (Lord Justice Munby, 2012c; Ruck Keene, 2012), and the Supreme Court will no doubt be asked to address these matters when it rules on *Cheshire* and *P & Q* in 2013. In the meantime, *Cheshire* is widely taken to be the leading authority on the meaning of deprivation of liberty for the purposes of DoLS and the MCA, and the comparator approach is still being applied by the High Court.<sup>901</sup>

## 6.5 DISCUSSION

The difficulties caused by these complex and contradictory court rulings on the meaning of deprivation of liberty cannot be overstated. Research conducted soon after the DoLS came into force<sup>902</sup> found total agreement in judgments regarding deprivation of liberty between panels of professionals who worked with the DoLS was 'slight' (Cairns et

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<sup>901</sup> *CC v KK*

<sup>902</sup> The authors report that the research on lawyers was conducted in October 2009 (Cairns et al., 2011b), they do not give a data for research involving psychiatrists, best interests assessors and IMCAs, although the case studies the research was based on were compiled during the summer of 2009.

al., 2011a; 2011b).<sup>903</sup> In response to *Cheshire*, best interests assessor Sue O'Neal complained:

I am no longer confident that I know how to do my job... As a trainer of acute hospital staff, I feel that I no longer know how to explain how they are to identify cases that may amount to deprivation of liberty, when it goes without saying... that the objective 'purpose' of medical and nursing interventions is always, one would hope, to save life and limb.<sup>904</sup>

In the first quarter following the ruling in *Cheshire* the official statistics on DoLS applications showed a decline for the first time (NHS Information Centre for Health and Social Care, 2012g). However, whilst the ruling has dismayed many,<sup>905</sup> there are those who regard it as offering clarity and a 'common sense' approach to the scope of the DoLS (Curry, 2012; King's Chambers, 2011; Henderson, 2011; Spain, 2011). Despite the claims of some to have found a clear and easy to apply the *ratio* in *Cheshire* and *P & Q*, later cases such as *C v Blackburn and Darwen* and *CC v KK* have continue to offer interpretations or extensions of the decisions which have taken the ruling much further, with sometimes surprising results.

The inconsistency between domestic and ECtHR case law raises the question of whether those detained under Strasbourg's approach, but not under the domestic courts', should be entitled to safeguards, or alternatively to compensation for unlawful detention under Article 5(5). It is usually assumed under the HRA that where domestic and Strasbourg authorities conflict, that domestic authorities must prevail until an appellate court can overturn the problematic domestic authority.<sup>906</sup> However, it has been suggested that it is possible that as s64(5) MCA states 'references to deprivation of a person's liberty have the same meaning as in Article 5(1) of the Human Rights Convention', for the purposes of the MCA (but not the HRA) the meaning of Article 5 should be supplied by Strasbourg directly (Ruck Keene et al., 2012f: 7).

Whatever the technicalities of *stare decisis* for the DoLS, the result of complex and contradictory domestic rulings, aggravated by their divergence from Strasbourg, is considerable uncertainty over when the safeguards should be applied. From a practical perspective this is clearly problematic and unsettling for all concerned. From a

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<sup>903</sup> The panels comprised 'six eminent barristers and solicitors with expertise in mental health law', six consultant psychiatrists, six IMCAs and five BIAs. Out of twelve vignettes based on clinical case studies, the professionals were unanimous in only one case that a person was deprived of their liberty, and agreement levels were lowest amongst the 'eminent' lawyers themselves.

<sup>904</sup> Ruck Keene et al (2011: 10).

<sup>905</sup> The ruling has met with particular dismayed responses from social care practitioners ('Ermintrude', 2011; Norman, 2011; Samuel, 2011c).

<sup>906</sup> *Kay & Anor v. London Borough of Lambeth & Ors* [2006] UKHL 10, [2006] 2 AC 465;

*R (RJM) v SSWP* [2008] UKHL 63; [2009] 2 All ER 556

republican perspective it means that the very mechanism which is supposed to safeguard against arbitrary detention is itself subject to highly arbitrary application. The rulings offer up such a diverse menu of rationales for finding that a person is not deprived of their liberty, that those who seek to avoid applying the safeguards can happily take a 'pick and mix' approach and claim Article 5 is not engaged in almost any circumstance. In this uncertain and unpredictable landscape Charles J has advised that public authorities should authorise 'borderline cases' in order to provide legal protection to provider, commissioner and 'P' alike.<sup>907</sup> Yet, sadly, the courts in *CC v KK* and *C v Blackburn with Darwen* did not appear to take this approach, and are likely to encourage others to apply a very high threshold to the engagement of the safeguards, even in the light of the divergent Strasbourg authorities.

There are undoubtedly BIAs and DoLS teams out there who use these judgments in the most expansive way possible to maximise the protection offered by the DoLS. No doubt these authorities and practitioners will be frustrated by the limitations imposed on their work by *Cheshire* and *P & Q*. Once again, however, we see that the application and operation of the safeguards is to a very significant degree determined by the good faith and attitude of those applying them. This means that the DoLS may offer many fantastic opportunities for those working within the system for better protections, and to challenge restrictions. But it also means that people with disabilities are subject to the whims and caprices of those with authority over them. It matters not, from a republican perspective, that some of those in positions of authority act as benevolently as they can; from a republican perspective what matters is the shortfall in protection if they do not.

One solution to this uncertainty over the scope of the DoLS would be to draft a statutory definition which sets out in clear and unambiguous terms when the safeguards should be engaged. This approach was called for by many respondents to the DoLS consultation and by the Joint Committee on Human Rights (2007b: [89]). This is also an approach which the Scottish Law Commission (2012) recently endorsed, in a consultation on introducing deprivation of liberty safeguards for Scotland, after a wry discussion of the tortuous English and Welsh case law. A statutory definition, if well drafted, could provide greater legal certainty and foreseeability for all – including care providers and supervisory bodies who face a theoretical risk of litigation for unlawful deprivation of liberty if they fail to apply the safeguards where they should have. However, any attempt to formulate such a definition would be likely to give rise to significant heated debates amongst disabled people's organisations, public authorities, care providers and the government.

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<sup>907</sup> *A Local Authority v PB & Anor* [2011] EWHC 2675 (CoP) [64]

The debates over the appropriate scope of Article 5 must be better understood as a proxy struggle for the scope of protective safeguards for involuntary placement and restrictive care. This legalist approach has met with resistance, as it has always done, by those who would prefer that those caring for adults with mental disabilities are afforded more discretion and carry less heavy ‘bureaucratic’ burdens to account for, and face challenges to, the exercise of that discretion. The polarised positions in this debate were in evidence at a recent seminar on deprivation of liberty (One Crown Office Row, 2012). Eminent panellists including Professor A C Grayling and Philip Havers QC commented that situations like *Cheshire* were not what the Convention drafters really had in mind<sup>908</sup>, and to call these a ‘deprivation of liberty’ would lead to an excessive administrative burden. Professor Grayling and other panellists drew comparisons with the restrictions imposed upon children to emphasise that paternalism was clearly justified in such circumstances, and there were no obvious human rights violations occurring. From the audience, the OS<sup>909</sup> asked ‘how disabled does a person have to be before they cease to have human rights, or an Article 5 right?’, before adding ‘one can be flippant about little children if one wants, but these aren’t children, they’re adults.’ The OS’s argument for expanding the scope of the DoLS, no matter how ‘troublesome’ in bureaucratic terms, was an argument for republican liberty in a nutshell: ‘Quite often people need protection, but not with the state assuming control without any regulation of that control.’ Or as barrister Joe O’Brien (2012) asked rhetorically at a recent conference on the MCA, ‘without the DoLS, how else is an incapable adult supposed to protect themselves?’

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<sup>908</sup> A similar point is made by Mostyn J in (High Court), and Munby LJ in *Cheshire*.

<sup>909</sup> Who has argued in *Re RK, P & Q* and *Cheshire* that the claimants were deprived of their liberty, and who took the decision to appeal *P & Q* and *Cheshire* in the Supreme Court. In the seminar, he indicated he would be prepared to pursue this case in Strasbourg.

# CHAPTER 7 – DISCUSSION

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When people with learning disabilities are ‘placed’ in institutional care services, they are exposed to a range of interferences with their choices and freedoms. These interferences include the imposition of rules and regimes by institutional authorities, surveillance, a loss of private space and encroachments upon bodily integrity, being subjected to restraint, seclusion and sedating medications, and restrictions may be imposed over their dealings with others outside of the institution. Such interferences have been found across the entire spectrum of care services, even in those which were initially designed to replicate the choices and freedoms of living in one’s own home.

As Goffman and others have argued, their cumulative and pervasive effects can be monumentally detrimental to self and wellbeing. Yet few in the policy and regulatory literature have argued that it is *never* appropriate to restrict a person’s choices and freedoms in care services. Rather, the literature highlights a range of situations where such restrictions occur but are unjustified according to particular normative criteria. The essence of such concerns is that restrictions are being imposed on an unprincipled and arbitrary basis. This I call the problem of ‘institutional domination’, whereby institutional authorities, including those commissioning such care, exercise *de facto* powers to impose a range of arbitrary interferences on people with learning disabilities, with little likelihood that those affected will challenge them.

## 7.1 THE LOSS OF FAITH IN LEGALISM

The republican solution to the problem of domination is to ensure that there are clear and well known principles which spell out which interferences are permissible, and in what circumstances. There must, furthermore, be effective methods of enforcing those principles. Although republicans do not believe that law is the only means by which this can be achieved, they regard the rule of law as fundamental to constraining the arbitrary exercise of power by state and non-state actors alike. Since the 18th century, we have turned to law to try to constrain the acts of institutional authorities responsible for the care and control of people with mental disabilities. Yet during the 20th century there was a shift away from legalism, prompted by a belief that community based care services – rather than legal controls – would be best placed to ensure good and humane care. Although ‘legalism’ was in part restored in psychiatric care, this has not been the case for most of the community based settings where the majority of people with learning disabilities live. Kathleen Jones (1980: 14) expresses this loss of faith in legalism most forcefully:

There are limits to what the law can do, and the present need is not for more law, but for an 'open-textured' law backed by good policy. The mental health services have been allowed to drift while reformers concentrated on minor issues... The need is not for increased legal formalism, but for human compassion and professional skill.

Jones' rejection of legal formalism was based on a belief that the problem was not one of constraining professional discretion, but 'because deteriorating morale and conditions of work, have facilitated the development of a vicious subculture, and the Law could not contain or negate it' (p14).

Others, who are less likely to share Jones' view that we should leave disciplinary professionals alone to get on with what they do best, have also rebuked the 'turn to law' to address the oppression of excluded social groups. The law, it is argued, does not hold disciplinary power in check, but *constitutes its authority*; law does not oppose disciplinary power but is *colonised by it*. Furthermore, law is a resource which is tapped by the powerful – barring a few token cases – and so it is the powerful who shape its development, thus re-inscribing in law the very inequalities it was meant to address. At base, the reason for this is that law is built upon a liberal myth of a particular kind of legal subject: one who is rational, unencumbered and self-sufficient. Those who do not conform to these expectations find themselves written out of law's empire; unable to access it, subjected to a range of filters and barriers to ensure their deviant subjectivity does not snarl up law's elegance, efficiency and self-referential logics.

In recent times, legal efforts to further disability rights have been connected with exposing this 'myth of the masterless man' (Lewis, 2011; Quinn, 2011b), with thinking new forms of law based upon a more inclusive subjectivity. Yet even these scholars and campaigners have turned away from 'legalism' and the use of procedural safeguards (Gooding, 2012: 9-10; Quinn, 2011b: 62), calling for legal efforts to focus on supporting the exercise of legal capacity rather restraining disciplinary power, as if these were binary alternatives.

## 7.2 LEGALISM RECOVERED?

This thesis, I suggest, provides several reasons for believing we should approach these calls to turn away from legalism and procedural safeguards with some caution. In response to Jones, it is certainly the case that a relentless focus on 'civil and political' rights, without regard to economic and social rights, will be doomed to failure. As Arnardóttir and Quinn (2009: xviii) write, in the context of disability – and no doubt in many other contexts – civil and political rights are interconnected with and dependent upon social and economic rights. This thesis is littered with examples of this: a person's



'right to liberty' is so often dependent on the availability of support to obviate the basis for detention; a person's ability to assert their rights through law is so often dependent upon practical and legal assistance to do so; a person's ability to meet the functional criteria for mental capacity will be dependent on support and opportunities to learn to make good decisions.

Yet one can agree that 'rights' to liberty, to legal capacity, are dependent upon support, without agreeing that formal procedural safeguards are unimportant or *inevitably* ineffective. It is true that the legal formalism of the 19th, 20th and 21st centuries has not prevented an array of horrifying abuses of power in institutional care. Yet it is surely not correct to argue that because these legal efforts failed, the law should simply turn away from these problems? That those who are detained should have no legal avenue to challenge their detention; that those whose 'support' has become malignant and domineering should have no legal recourse?

The experiences of the MCA and the DoLS offer a number of important reminders. In the first place, that inscribing fine sounding, but ultimately abstract, principles into a statute is no guarantee that those principles will be interpreted in ways which satisfy the hopes of reformers. Like a Rorschach test, admirers of the MCA can project onto it their own personal values – be they of a libertarian or paternalistic bent, as the MCA accommodates both – whilst 'wrong' outcomes can be attributed to a 'wrong' interpretation in a particular case. No doubt the sheer vacuity of the MCA's principles helps to explain its enduring popularity. The Act flatters caregivers and disciplinary professionals that they are appropriately placed to judge whether a person *really* understands and appreciates a particular decision, and what course of action would *really* be in their best interests. The Act imposes few constraints upon those judgments.

As Quinn (2009: 217) has written of the CPRD, 'the text alone does not guarantee that its values will be transposed into the worldview of policy and law-makers': there will always be 'textual toeholds' which can temporise profound reforms. Yet if reformers really do want profound reform of the normative principles which inform the acts of professionals, carers, supporters and courts, they will need to offer better answers than they have yet done to the practical and ethical difficulties of interpreting their worldview in real life. Almost all the literature associated with Article 12 CRPD suggests that it is unacceptable to *ever* override a person's wishes and preferences, where they can be discerned, on disability related grounds (e.g. Centre for Disability Law & Policy, 2011; Dhanda, 2006-7; Minkowitz, 2006-7). Yet does this *really* mean they would have support workers allow P to ingest and choke on his soiled incontinence

pads?<sup>1</sup> That they would leave Mrs EH, without sufficient clothing in cold weather and at risk of hypothermia, scrambling down the embankment of a busy main road?<sup>2</sup> Is this the ‘dignity of risk’, the opportunity to learn from one’s mistakes, that they are vaunting? I, for one, doubt that it is. Yet unless reformers supply clear criteria to help us distinguish between an intervention to stop P choking or Mrs EH wandering in front of traffic from those interventions which *are* unacceptable, they leave open the door to unconstrained authoritarian power. Reformers need to spell out much more clearly what risks the ‘new paradigm’ would be prepared to tolerate, and it must confront those which it would not.

Reformers should take note of what happened in England and Wales when guardianship was all but abolished: the courts made far reaching use of the doctrine of necessity, including uses such as non-consensual sterilisation which most disability rights campaigners would find abhorrent,<sup>3</sup> because the law contained no principles to prevent it. There is a need, as Quinn (2010: 17) himself has said, ‘to identify toeholds on the slippery slope that will forestall the possibility that the exception (making ‘decisions for’) becoming the norm.’ Analysis of MCA case law suggests there are other places where such ‘toeholds’ will be needed. Of particular significance for the CRPD are those areas where the distinction between support and coercion are unclear: from the influence of overbearing family members on decision making, to the (compulsory) insertion of people with learning disabilities into ‘independent living’ services to *enhance* their decision making capabilities. The task of constraining discretionary power within acceptable limits is Sisyphean. We will never reach a point when the meanings of words are certain, where new dilemmas and uncertainties do not emerge, because meanings can always be contested and can never be fixed (Laclau and Mouffe, 1985; Wittgenstein, 2001). But neither should we forget the power of words to guide and constrain, to encourage and deter. These are transient and contingent powers, no doubt, but this should not lead us to apathy but, as Foucault (1994a: 256) puts it, ‘to a hyper- and pessimistic activism.’

The lesson of the DoLS is that if legalism has failed to prevent abuses of power, it is very often for remediable defects. I suggest that we can draw from the critical analysis of the DoLS in this thesis several important indicators of what a better form of legalism would entail:

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<sup>1</sup> *Cheshire*

<sup>2</sup> *Dorset County Council v EH* [2009] EWHC 784 (Fam)

<sup>3</sup> *Re F. (Mental Patient: Sterilisation)*

1. Where a person is subject to an interference with their rights, they must be supported to understand it as such, and to understand the means by which they can contest it.
2. Support to bring such a challenge must be readily accessible.
3. Support should be made available on the basis that if a person needed to bring a challenge, they would need support; not that others agree that a challenge should be brought. People should not have to ‘coat-tail’ on the back of disputes between other figures in their lives for their concerns to be heard by a court.
4. It is imperative that people are fully supported to adversarially contest all the evidence and arguments which form the basis for an interference with their rights. This inevitably means, contra *RP v UK*, that their *subjective* interests must be represented in the legal process, even if they require special assistance to do so.
5. In order to forestall the tendency for disciplinary and familial discourses and ‘expertise’ to drown out the voices of peoples with mental disabilities, they must be supported and enabled to participate in proceedings which are about them as far as possible.

The potential strengths of the DoLS do not arise because of a person’s detained status, whatever that even means, they arise because Article 5 safeguards are fundamentally oriented towards constrain arbitrariness, where mechanisms like the MCA are not. Whereas the ‘informalism’ of the MCA is entirely founded upon the belief that caregivers and disciplinary professionals usually make good decisions, in the words of the ECtHR and Lord Steyn in *Bournemouth*, ‘the very purpose of procedural safeguards is to protect individuals against any “misjudgments and professional lapses”’.<sup>4</sup> In republican language, the MCA simply hopes that you have a good ‘master’; the DoLS try to make him less of one.

One difficulty with legalism as traditionally conceived is that it has – since the 18th century – treated institutional admission as a separable issue from the institutional conditions. As argued throughout this thesis, the conditions within a setting are intimately linked to the extent to which it is suitable for the individuals within. Where a particular ‘placement’ is manifestly unsuited to a person – where they are unhappy, where their needs for support cannot be met, where they are isolated and excluded from family and community – the problem is not necessarily either the setting or the person,

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<sup>4</sup> *HL v UK*, [121].

but that *this* person should not be in *that* setting.<sup>5</sup> Traditional legalism has tried to tackle these issues separately. Detention safeguards like the MHA have asked whether a particular individual should be confined to an institution (any institution). Meanwhile, regulation has asked whether a service is ‘good’, without being able to address the more nuanced question of whether it is good for some but not for others.

Neither detention safeguards nor regulation are well suited towards examining the fit between individual and environment; yet the social model of disability tells us this is precisely what we should be doing if we are serious about supporting people appropriately. The much-maligned DoLS, meanwhile, do offer better prospects than existing frameworks such as detention and guardianship under the MHA for examining this relationship. Unlike the criteria for detention or reception into guardianship, the best interests qualifying requirement forces assessors to ask whether the particular placement is really the best available option for that person, and whether particular restrictions a person is subject to therein are really necessary and proportionate. Regrettably I have only been able to offer a few examples in this thesis of the transformative potential of DoLS best interests assessments and the use of conditions to lever improvements in care planning and delivery. Much more research would be needed to generalise from this that DoLS *do* achieve such remarkable results; but this research suggests that they certainly *can do*. And, moreover, they may be able to do this without resort to a court at all.

The danger that law becomes ‘colonised’ by disciplinary power is all too much in evidence in the MCA and its case law, but as Golder and Fitzpatrick (2009) write, this colonisation is contingent and not an inevitable feature of law. We must exploit ‘this receptivity of the law, this ever-opening by which the law disrupts its determinate self and by which it is incipiently attuned to ‘the outside into which it is always receding’ (Golder and Fitzpatrick, 2009: 79). Re-colonising the law with the voices of disabled people will take radical reforms, no doubt, but our imaginations must be directed towards these. The voices of disciplinary professionals are inserted into law not merely as parties to cases, but also as ‘experts’; is it really beyond the realms of possibility that people with disabilities could themselves be a source of expertise which the law could draw from? Why do disabled people’s organisations intervene so rarely in cases related to the MCA; do they really have nothing to say about the acceptable boundaries of interventions under the MCA, about the state of the DoLS? Is Freyenhagen and O’Shea’s (2013: 29) suggestion that ‘those who have experienced life with these conditions might have to be

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<sup>5</sup> The case *C v A Local Authority* is an excellent example of this.

included as lay members onto case review panels – just as already mental health tribunals often include lay members’ really so improbable?

### 7.3 LEGALISM FOR THE FUTURE

Legalism has been tried and has failed. But form is everything, and we have yet to see a legalism that takes a form that fully recognises the subjectivity of people with mental disabilities - the kinds of oppression they face, and the kinds of support they will need to hold authority to account. Many questions remain about the form the legalism of the future can, and should, take. For the most part in this thesis I have focussed on the formal and procedural questions of arbitrariness in discretionary decision making and the efficacy of mechanisms of enforcement, rather than looking at the substantive principles of the MCA themselves. I now offer some tentative remarks about substance.

Given the literature on the kinds of interferences people with learning disabilities – and other disabilities – experience in institutional care, it is tempting to conclude that it would be better to abolish altogether any laws which could permit acts which modulate a person’s ordinary legal rights to self determination on disability related grounds. Indeed, this appears to be what some interpretations of the CRPD call for. I agree that ‘incapacity’ is insidious, that the MCA appears to have legitimated a vast range of interferences which have massive, and often detrimental, repercussions for people with disabilities. I understand the temptation to conclude that legal devices which label some individuals, or some decisions, as suitable to be overridden are so dangerous they should be abolished altogether.

However, as I observed earlier, there are – I believe – a narrow range of situations where it is extremely difficult to see how to proceed if one respects absolutely a person’s ordinary legal rights to liberty and privacy. Earlier I suggested that the tendency of P in *Cheshire* to eat, and choke on, his incontinence pads was one such example, the case of Mrs EH another. I have encountered many such situations – as a care worker, and in my personal life. Such situations included a care worker having to force her way into the home of a woman who appeared to be having a stroke, and physically restraining her to prevent her from setting her home on fire or wandering naked into the road whilst waiting for an ambulance. In hospitals, patients with acute infections refuse antibiotic treatments which could save their lives, on the basis of terrors and delusions arising from the infection itself.<sup>6</sup> As I wrote in the first chapter, I have worked with a man who would try to ingest anything, hurtle towards dangers he did not

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<sup>6</sup> It is important to recall that ‘incapacity’ is also applied to people with illnesses which would not constitute disabilities, and even to people in toxic states, highly emotional states and a wide range of other conditions.

understand.<sup>7</sup> In such circumstances, it is very difficult indeed to see how to do without a device which even if it does not call itself 'incapacity' and does not explicitly incorporate a diagnostic threshold serves a similar purpose and can be put to similar ends. The requirements of the MCA that the 'least restrictive option' should be considered, that any interferences should be for the benefit of the person themselves and not others, are not objectionable - but they are insufficient. Yet once we have agreed that in some, limited, circumstances interventions which are – undeniably – related to disability or illness are permissible, a number of problems present themselves.

As Dhanda (2006-7: 445) asks, 'by what procedure will this small percentage of persons be identified?' One of the difficulties with 'decision specific' capacity, as I argued in Chapter 4, is that it potentially renders all the decisions and acts of people with disabilities open to question. So constraining the point at which such questions can be posed is critical. Under the MCA there is no such threshold; one possible approach would be to try to formulate one, although it is very difficult to envisage one which would be attractive across the broad range of situations which the MCA applies to. One strategy might be to require that there must be evidence of real and immediate danger before it is permissible to resort to strategies which involve impinging upon a person's rights to self-determination.

This would constrain the extent to which the MCA could be used to stage major non-consensual interventions in cases like *K v LBX*, where there is no major risk but the outcome is thought merely to be 'better', or somehow preferable in light of certain policy objectives. Arguably, the low threshold established in *K v LBX* opens the way to using the MCA for *tinkering*, and by lowering thresholds for intervention may reduce the pressure to find collaborative strategies. I suggest that this option requires further attention, but that this should take place in a democratic arena where a broader range of perspectives can be consulted. I suggest that we also need to be cautious about progression towards holding caregivers responsible for all the harm that befalls those whom are later labelled, with alarming ease, as 'lacking capacity'. Again, it would be preferable to canvass a broader range of perspectives, not least those of disabled people themselves, before the law proceeds further in this direction.

A second issue is the little-addressed question of 'who decides?' The ordinary practice of using clinicians to assess capacity, and of disciplinary professionals making major 'best interests' decisions on behalf of people, is virtually unquestioned in commentaries on the MCA. Yet *why* should these groups be afforded these roles? – this

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<sup>7</sup> Although I would not, for one moment, condone the 'solution' that service arrived at; the service itself was not equipped to cater to his need for secure, but open, spaces to run around in, and provide tactile and olfactory stimulation.

is not the case in all other jurisdictions. In British Columbia in Canada, for example, substituted decisions for people who 'lack capacity' around medical treatment and placement in care facilities are not taken by professionals except in emergencies. Decisions are either taken by guardians, by a person's nominated representative, or through a relative selected from a statutory list (Gordon, 2012). One of the major substantive critiques I would levy at the MCA is that it empowers almost anybody who proposes some act of care or treatment, and is in a position to provide it, to decide whether or not that person has the capacity to consent to it and whether they should deliver it anyway in that person's best interests.

This is quite extraordinary when one stops to think about it. Imagine if hairdressers routinely stopped people in the street, decided that they lacked the capacity to make decisions about their hairstyle and imposed haircuts on them in their best interests, *just because they could cut hair*. We have become so accustomed to disciplinary authority over the lives of people with disabilities, we barely stop to notice it. The emphasis on relationships and relational autonomy in the literature associated with the CRPD is not without its shortcomings, but it does at least force us to ask – who would we want to make decisions on our behalf, if we were unable to express a view or in those rare circumstances when our will should be overridden? Few, I suggest, would say 'anybody who works in care services'.

A third question is what criteria should be used for coercive interventions or interventions which conflict with a person's will and preferences where these occur. The MCA's best interests standard has been described as 'the weakest standard for respecting previous self-determined choice' (Samanta, 2010: 384). This is thought to increase the risk that the values of decision makers will inform best interests decisions, and some suggest that the old 'substituted judgement' standard would be less paternalistic (Boyle, 2011: Samanta, 2010). Whilst acknowledging that substituted judgement might be more attractive in principle, the Law Commission (1995: [4.22]-[4.23]) expressed concern about situations where a person's views were not known, where they had never had capacity, or they had always been a poor decision maker. However, these need not be binary alternatives – the approach taken under the Representation Agreement Act 1996 (British Columbia), for example, starts with an outcome approach – is the person's choice 'reasonable'? – before switching to substituted judgement, and it is only if a person's past or present values and beliefs are not known that decision makers may resort to 'best interests'. Bach and Kerzner (2010) suggest a post-structuralist inspired 'narrative approach'. Smull and Parsley (2003) recommend a duty to promote self-determination. Whatever approach is taken, however, one cannot escape the reality that substituted decision makers will still exercise

considerable scope for interpreting whether a person's currently expressed preference is part of their overall 'narrative' or 'values'. As Schmitt (1922: 1) would put it, "Sovereign is he who decides on the exception".

An important avenue for future research will be to look at the relational elements of supporting capacity and making substituted decisions, at mechanisms like the British Columbian representation agreements.<sup>8</sup> Such research will need to be more attentive than the disability rights literature has hitherto been of questions of power, and how one guards against support which becomes malignant or domineering. Safeguards to address such situations must be available and accessible.

This leads me, last of all, to efforts towards deinstitutionalisation. For people with learning disabilities, no program of reform could be more important than lessening the hold of institutions over their lives. The horrors of long-stay hospitals like Ely, Budock and their 21st century privatised progeny in Winterbourne View loom large on the horizon. Yet, as I argued in Chapter 2, we should remain vigilant, knowing that 'institutionalisation' is linked to a set of practices perpetrated by a body of caregivers and 'support staff': institutions can be found in any kind of service, can be found in people's own homes. The reason for this, I suggested in Chapter 2, is that the institution has followed the 'tutelar relationship' which people with learning disabilities are so often subject to, out from the hospitals and into the community. It has even followed them into their own homes. And this tutelar relationship is, as Unsworth (1991: 254-5)<sup>9</sup> observes, intimately linked to practices associated with incapacity:

...the liberal-contractual society emergent in the late eighteenth and early nineteenth centuries, faced, in the mentally disordered, with subjects who could neither participate in rational exchange nor be held responsible for their actions, relegated them to a special subordinate legal status. Rather than being constituted as active subjects vested with rights over which they could exercise autonomous control and exclusive dominion, they were placed under a *relation de tutelle*, or relationship of tutelage or guardianship, within which they were legally guaranteed to be subject to a regime of (principally medical) paternalism.

We should be cautious of believing that the 'new paradigm' abolishes this tutelar relationship; it seems more likely to be a transformation, albeit an important one. Few

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<sup>8</sup> Representation Agreement Act (British Columbia) 1996. One could also, I believe, make a republican argument for shifting the balance of power away from professionals towards 'informal' and familial sources of support. Inevitably, when care and welfare decisions are being made, supporters would come into contact with professionals commissioning or providing care and treatment. If those professionals have concerns about 'informal' supporters and substituted decision makers they are much better placed to use the law to challenge their authority than informal decision makers are to challenge professionals.

<sup>9</sup> Unsworth cites Castel (1988) as the source of this thesis.



today would hold that plenary guardianship was an acceptable measure, yet it does have in common with support paradigms agreement that decision-making deficits exist. Quinn (2011a: 40) describes the 'support paradigm' as shifting the response to these deficits, not denying their existence. Yet the modes of support necessary for 'assistive thinking' or supported decision making are not, *contra* Francis and Silvers (2010), comparable to a prosthetic limb or a golf buggy. They involve human agency; in particular they involve agents who have skills, abilities and resources which those with 'decision making deficits' do not. Of particular note are their enhanced discursive powers, which have been found time and again in studies using Conversation Analysis to place 'supporters' in positions of power, however benevolent their intentions (Antaki et al., 2009; Finlay et al., 2008a; Finlay et al., 2008b; Jingree et al., 2006; Jingree, Treena and Finlay, 2008). The support paradigm will still entail people with mental disabilities being exposed to the risk of domination; it cannot not, because wherever there is a power imbalance and dependency, the conditions for domination to take root are present (Lovett, 2010a). The key is constraining that power.

People will be at risk of institutionalisation in any setting for as long as they exist in some kind of tutelary relationship – whether it is formalised as guardianship, takes an informal form such as the MCA or is transformed by the support paradigm. This is because their acts will always be subject to some level of surveillance to look out for 'decision making deficits' or risky actions and take action accordingly. Even if we embrace a greater tolerance for risk, there will be some risks, I believe, that we will not tolerate. There will be some people, like P in *Cheshire*, whose lives will always be subject to interferences of some kind or another – but that does not mean we should rest from finding ways to minimise these, to support his flourishing as best we can. I have argued here that the bar for such interventions must be raised, that their legitimate scope must be nailed down with much more detailed guidance than open-ended aims to pursue a person's 'best interests' or even to 'support capacity'. Those exercising powers to influence and intervene should be called upon to justify it, should face scrutiny, and should regard the person whom they exercise it over as a realistic source of a challenge to their authority should they overstep the mark.

I suggest that to enable this, the following steps must be taken:

1. There is a need, as Mostyn J expressed in *J Council v GU & Ors (Rev 1)*, for much clearer guidance over which interferences are, and are not, permissible in care settings. This guidance should be produced with input from disability rights reformers, who should be able to provide advice on the kinds of

interferences which are, and are not, acceptable and which risks will, and will not, be tolerated.

2. People who use care services who exist, or are at risk of existing, within a tutelary relationship, should be given access to long-term, independent advocacy, where those advocates are required to support them in holding authority to account.
3. Relationships of support for decision making, which are not malignant or domineering, should be recognised as such, rather than dependence being identified as evidence of a person's incapacity. The state and care services should be under a duty to actively foster supportive relationships and environments which are conducive to decision making.<sup>10</sup> It is doubtful, however, that providers and commissioners of care are suitably placed to take on such a role themselves, given the potential for conflicts of interest.

Even these reforms will not, however, be sufficient to ensure people with learning disabilities are as free as possible from institutionalisation, social exclusion and other forms of oppression. The roots of these evils run deep in our society, and can be traced through their exclusion from democratic and political mechanisms, through welfare reforms which exacerbate dependency and prioritise the efficiencies of 'batch living' (Goffman, 1961) over personal flourishing. It can be traced through the lack of credibility they encounter in their daily interactions, through failure to recognise that people with learning disabilities have the same capabilities and needs as anybody else if they are given the means to enjoy them. Incapacity, undeniably, plays a role in these processes. In legal terms it creates a mechanism whereby the understandable objections and outrage people experience at their subjection, confinement and institutionalisation can be overridden and contained. It confirms, in law, that their views are less credible, that they are fundamentally 'other'. Yet it is essential that the law is able to respond, in some way, to disability and difference – be it through MCA, the DoLS, or the CRPD. And all the solutions advanced so far have only paradoxes to offer.

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<sup>10</sup> See s9 The Draft Rights of Persons with Disabilities Bill 2012 (India) for an interesting example of such an active duty, which is far less situation-specific and qualified than the duties to support decision making under the MCA.

'My point is not that everything is bad, but that everything is dangerous, which is not the same as bad. If everything is dangerous, then we always have something to do. So my position leads not to apathy but to a hyper- and pessimistic activism.'

Foucault (1994a: 256)



# APPENDIX A – FREEDOM OF INFORMATION ACT 2000 REQUESTS

Table 2 Table of Freedom of Information Act 2000 Requests

#	Body information requested from	Nature of information requested	Date requested	Date received	URL to documents
1	Office of the Public Guardian	Demographic data on people with deputies or active LPAs; Number of complaints by P about his LPA and deputy, number of investigations proceeding from those complaints.	06-Jun-12	20-Jun-12	by email
2	Devon and Cornwall Constabulary	Report of police investigation into the abuse of adults with learning disabilities in services operated by Cornwall Partnership NHS Trust, dated 2009 and entitled 'Operation Apple'. The report was redacted to protect identities.	01-Jun-10	22-Jun-10	<a href="http://www.devon-cornwall.police.uk/YourRightInformation/FreedomInformation/Pages/DisclosureLogs.aspx">http://www.devon-cornwall.police.uk/YourRightInformation/FreedomInformation/Pages/DisclosureLogs.aspx</a>
3	Crown Prosecution Service	Data on the number of prosecutions initiated by the CPS under s44 MCA and s127 MHA (2007-9)	27-Oct-09	12-Nov-09	<a href="http://www.cps.gov.uk/publications/docs/foi_disclosures/2009/disclosure-63.pdf">http://www.cps.gov.uk/publications/docs/foi_disclosures/2009/disclosure-63.pdf</a>
4	Crown Prosecution Service	Data on the number of prosecutions initiated by the CPS under s44 MCA and s127 MHA.= (2009-12)	23-Jul-12	07-Aug-12	<a href="http://www.whatdohheyknow.com/request/prosecutions_under_s44_mental_ca">http://www.whatdohheyknow.com/request/prosecutions_under_s44_mental_ca</a>
5	Care Quality Commission	Data on the development of the Quality and Risk Profile methodology, and the risk profile of Winterbourne View hospital.	08-Jun-11	05-Jul-11	<a href="http://www.whatdohheyknow.com/request/quality_and_risk_profiles">http://www.whatdohheyknow.com/request/quality_and_risk_profiles</a>
6	Care	Data on expenditure and the number of care	03-	01-	<a href="http://ww">http://ww</a>

	Quality Commission	homes and domiciliary care services registered with NCSC, CSCI and CQC and the number of inspections annually, 2003-2011	May-11	Jun-11	w.whatdohheyknow.com/request/data_on_inspections_of_care_home
7	Care Quality Commission	Data on the number of care homes, domiciliary care services and hospitals registered with CQC and the number of inspections in 2011-12, broken down by type of service user.	13-Aug-12	05-Sep-12	by email
8	Care Quality Commission	Data on inspection of registered services in 2010-11 broken down by type of service user	10-Jul-12	10-Aug-12	by email
9	Care Quality Commission	Data on enforcement action taken by CQC between April 2010 and February 2012	12-Jan-12	09-Feb-12	by email
10	Local Government Ombudsman	Data on the number of complaints made concerning adult social care providers, including private providers. Qualitative information in response to questions about the LGO's relationship with CQC and its use of the MCA and HRA.	12-Jan-12	09-Feb-12	by email
11	Care Quality Commission	Information on the number of complaints received by the CSCI against care homes and domiciliary care providers.	12-Jan-12	25-Jan-12	by email
12	Care Quality Commission	Information on the number of services registered and inspected 2003-2010	03-May-11	31-May-11	http://www.whatdohheyknow.com/request/data_on_inspections_of_care_home
13	Department of Health	Information on the number of paid representatives and s39D IMCA referrals per local authority, in the first year. The request was initially refused on the basis that it would be published in the future, but it was not. It was then refused by the DH on the grounds that the NHS Information Centre held the data. They refused disclosure. A referral to the Information Commissioner's Office was unsuccessful as it transpired the Department of Health held the data. Eventually, the DH disclosed the data.	03-Mar-11	31-Jan-12	by email
14	Department	The basis for the Department of Health's	03-	21-	by email

	Department of Health	decision not to include supported living within the scope of DoLS; whether the Department of Health commissioned any research to estimate the number of people who might be deprived of their liberty in supported living; whether the DH was keeping records of the number of people deprived of their liberty in supported living by order of the Court of Protection; Whether the DH planned to review the scope of the safeguards to cover supported living. The final response came after several requests for clarification and review. The DH responded 'The Government did not include supported living because it considered it less likely that severe restrictions would be placed on people in supported living arrangements, who would tend to lead more independent lives' and 'As far as the department is aware, there is no estimate of the numbers of people who might be deprived of their liberty beyond care homes and hospitals.'	Mar-11	Jun-11	
15	Court of Protection	Number of appeals against deprivation of liberty under s16 and s21A MCA. Delay due to my request for more detailed breakdown of data.	14-Jan-11	01-Apr-11	by email
16	Court of Protection	Number of appeals against deprivation of liberty under s21A MCA and s16 MCA, updated.	16-Jul-11	22-Nov-11	by email
17	CAFCASS	A request sent by A. Watson via a third party website sought information from CAFCASS about the number of IRO referrals they had received.	24-Nov-11	26-Jan-12	<a href="http://www.whatdohheyknow.com/request/information_about_iro_referrals">http://www.whatdohheyknow.com/request/information_about_iro_referrals</a>
18	Office of the Public Guardian	A request sent by Mr Winston Lyon via a third party website sought information from the OPG about the number of Court of Protection visitors employed in England, by region, and details of the recruitment process for Court of Protection visitors, by region. The OPG responded to his request for information in full.	07-Oct-12	29-Oct-12	by email
19	Local Government Ombudsman	A request to the LGO for information on whether the LGO had received and investigated any complaints relating to the deprivation of liberty safeguards. The LGO confirmed that they had, and by way of example shared three unpublished	21-Jun-12	22-Jun-12	by email

		investigations into issues concerning the DoLS. These are reproduced with kind permission of the LGO in Appendix 2.			
20	Ofsted	Request for data on the number of a) children's social care services, and b) residential special schools, registered with Ofsted for each financial year; The number of inspections of a) children's social care services, and b) residential special schools, for each financial year; Ofsted's overall expenditure on regulation of a) children's social care services, and b) residential special schools, for each financial year; and Ofsted's expenditure on inspection only (separated from other regulatory costs) for a) children's social care services and b) residential special schools, for each financial year.	27-Jul-11	23-Aug-11	by email
21	Department of Health	Responses to 'DEPARTMENT OF HEALTH (2005) "Bournewood" Consultation: The approach to be taken in response to the judgment of the European Court of Human Rights in the Bournewood" case (Gateway Ref 267902, London)' from specified organisations requested from the Department of Health. These were returned by email, and have been placed in a zipped folder at the listed URL.	12-Oct-10	05-Nov-10	<a href="https://dl.dropbox.com/u/4397081/Thesis/FOIA%20data/Responses%20to%20the%20Bournewood%20Consultation.zip">https://dl.dropbox.com/u/4397081/Thesis/FOIA%20data/Responses%20to%20the%20Bournewood%20Consultation.zip</a>
22	Office of the Public Guardian	Responses to 'MINISTRY OF JUSTICE & DEPARTMENT OF HEALTH (2007) 'Mental Capacity Act 2005 Deprivation of Liberty Safeguards: Consultation Paper CP23/07 "' from specified organisations requested from OPG. OPG sent paper photocopies by post; these have been scanned in and placed in a zipped folder at the listed URL.	24-Jun-10	22-Jul-10	<a href="https://dl.dropbox.com/u/4397081/Thesis/FOIA%20data/DOLS%20consultation%20from%20LS.zip">https://dl.dropbox.com/u/4397081/Thesis/FOIA%20data/DOLS%20consultation%20from%20LS.zip</a>
23	Department of Health	Responses to 'DEPARTMENT OF HEALTH (2008) Consultation on the mental capacity (deprivation of liberty: monitoring and reporting) and (deprivation of liberty: standard authorisations, assessments and ordinary residence) (amendment) regulations 2009 (Gateway Ref 11057, Department of Health, London)' requested from Department of Health. These were supplied by email, and have been placed in zipped folder at the listed URL.	14-Oct-10	05-Nov-10	<a href="https://dl.dropbox.com/u/4397081/Thesis/FOIA%20data/Responses%20to%20the%20DOLS%20monitoring%20consultation.zip">https://dl.dropbox.com/u/4397081/Thesis/FOIA%20data/Responses%20to%20the%20DOLS%20monitoring%20consultation.zip</a>
24	Department	I contacted the DH to ask: 1) Whether the	03-	21-	email



	Department of Health	<p>Department of Health based its original decision not to extend the DoLS framework to 'supported living' or 'extra care' services on any research, and for copies/citations for that research; 2) Copies of any documents setting out the DH's reasoning that deprivation of liberty was likely to occur in supported living settings; 3) Whether the Dh based its decision not to extend the DOLS to supported living on any estimates of the numbers of people who might be deprived of their liberty in those settings and a copy of those figures; 4) Whether the DH kept a count of the number of people deprived of their liberty in supported living services by an order of the Court of Protection; 5) Whether the DH planned to review the scope of the safeguards to extend beyond care homes and hospitals?.</p> <p>The DH initially responded simply that 'The Government did not include supported living because it considered it less likely that severe restrictions would be placed on people in supported living arrangements, who would tend to lead more independent lives', but gave no detail as the basis for this belief. A follow up request for a review confirmed that 'the Department does not hold any research and is also unaware whether or not any such research exists' for the basis for this belief. It held no documents which could testify to the DH's reasoning that deprivation of liberty was unlikely to occur in supported living. It held no statistical estimates or information on the number of people who might be deprived of their liberty in supported living. They also stated 'whilst our previous response confirmed that the Department had no plans to review the scope of the safeguards, I can also confirm that extending the safeguards beyond care homes and hospitals was not considered by the Department so there are no documents or meeting minutes to this effect.'</p>	Mar-10	Jun-11	
25	Department of Health	<p>Responses of CSCI, HCC and MHAC to 'MINISTRY OF JUSTICE &amp; DEPARTMENT OF HEALTH (2007) 'Mental Capacity Act 2005 Deprivation of Liberty Safeguards: Consultation Paper CP23/07 "' requested. Supplied by email and placed in zipped folder and the listed URL.</p>	03-Aug	09-Aug	<a href="https://dl.dropbox.com/u/4397081/Thesis/FOIA%20data/Responses%20of%20CSCI%20HC%20and%20">https://dl.dropbox.com/u/4397081/Thesis/FOIA%20data/Responses%20of%20CSCI%20HC%20and%</a>

					20MHAC% 20to%20D OLS%20con sultation.zi p
26	Departme nt of Health	I asked the DH whether 'any further correspondence taken place between the Department of Health and the Care Quality Commission on the subject of compliance of the Deprivation of Liberty Safeguards with OPCAT, following the receipt of the document 'Joint CSCI, Healthcare Commission, MHAC response to chapter 8 of the Deprivation of Liberty safeguards draft addendum to the Mental Capacity Act Code of Practice?'' and requested copies of that correspondence. The DH replied 'Having searched our records, there has been no correspondence between the Department and the Care Quality Commission on the subject of compliance of the Deprivation of Liberty Safeguards with OPCAT since your last request dated September 3rd.' A request for clarification as to whether there had been any correspondence (including prior to September 3rd) on this resulted in confirmation that 'I can confirm that in both cases DH has not corresponded with Ministry of Justice or CQC on this matter'.	09- Sep- 10	29- Sep- 10	email
27	Departme nt of Health and NHS Informati on Centre	I contacted the DH asking for, amongst other things, 'the number of: section 39C IMCAs, section 39D IMCAs, unpaid representatives and paid representatives for each local authority up until 1st November 2010'. The DH confirmed they do not collect data on paid/unpaid representatives. I was offered collapsed data on s39C/D IMCAs. The data was then withheld under s22 FOIA on grounds it was for future publication, but it was never published. I was then passed to the NHS IC, who were said to hold the data. The NHS IC refused on the basis that it might be possible to identify individuals from the LA level breakdown. I complained about the decision to the Information Commissioner's Office (ICO), the ICO found that in fact the DH - not the NHS IC - held the data. I then applied again to the DH for the data. On 31 January 2012 the DH supplied the data with the following comment 'The data by category for 2009/10 were not published due to feedback from advocates, care homes and local authorities,	28- Feb- 11	31- Jan- 12	email

		which showed that there was considerable confusion over the understanding and recording of the different categories of DoLS in the first year. The decision was made at the time that the numbers inputted under the three categories were unreliable and unusable. However, this review has highlighted that, despite its erroneous nature, there are no legal grounds for withholding the information.'			
28	Law Commission	I asked the Law commission to provide copies of responses to 'LAW COMMISSION (2010) Adult Social Care: A Consultation Paper (Law Com No 192, London)' which 'were of the view that the Law Commission should have included proposals on complaints and redress.' The Law Commission were able to identify and supply those responses. They have been placed in a zipped folder at the URL.	18-Jul-12	18-Jul-12	<a href="https://dl.dropbox.com/u/4397081/Thesis/FOIA%20data/Responses%20to%20Law%20Com%20ASC%20consultation.zip">https://dl.dropbox.com/u/4397081/Thesis/FOIA%20data/Responses%20to%20Law%20Com%20ASC%20consultation.zip</a>
29	Local authorities in England	I sent out a 'round robin' request to all local authorities in England asking them a series of questions about their DoLS activity up to 1 November 2010. Questions included the number of court cases concerning the DoLS each LA had been involved in, the number of third party requests to consider whether an unauthorised deprivation of liberty was occurring received by each local authority and the number of times the CQC had brought a possible unauthorised deprivation of liberty to the attention of the local authority. Results for this FOIA request are given in Appendix 3.	01-Dec-10	07-Feb-2011	All requests were initiated via the website 'www.whatdotheyknow.com', however some responses were received via email. All requests by the author can be located from: <a href="http://www.whatdotheyknow.com/user/lucy_series">http://www.whatdotheyknow.com/user/lucy_series</a>
30	Local authorities in England	Matthew Hill, a journalist working for BBC Radio 4's <i>The Report</i> conducted a series of FOIA requests of local authorities asking them about the use of Part 8 Reviews and	Jun-11	Sep-11	email

		challenges to DoLS authorisations in the Court of Protection. He asked for my assistance in analysing the data, and kindly permitted me to share his findings in this thesis.			
31	Department of Health	A request for the DH to provide the responses to DEPARTMENT OF HEALTH (2005) Consultation on the Independent Mental Capacity Advocate Service (Department of Health, Gateway Ref 5090, London). The DH supplied the following responses: Action for Advocacy, the Alzheimer's Society, the English Community Care Association, the Law Society, Mencap, the Mental Health Foundation and the Foundation for People with Learning Disabilities, the Official Solicitor, the Royal College of Psychiatrists and the Royal College of General Practitioners.	25-Oct-12	23-Nov-12	<a href="http://www.whatdotheyknow.com/request/responses_to_imca_consultation">http://www.whatdotheyknow.com/request/responses_to_imca_consultation</a>
32	Office of the Official Solicitor and Public Trustee	A request for the Official Solicitor (OS) to provide data on the number of times he had acted as a litigation friend in appeals against detention brought under s21A MCA, the number of times he had withdrawn such an appeal on the basis it had low prospects of success, the supervisory bodies whom he had challenged in his capacity as litigation friend in a s21A MCA appeal and the outcomes of such cases. The OS declined to supply this data on the basis that he was not a public authority who was bound to disclose information under the FOIA.	29-Mar-11	12-Apr-11	<a href="http://www.whatdotheyknow.com/request/appeals_under_s21a_mental_capacity">http://www.whatdotheyknow.com/request/appeals_under_s21a_mental_capacity</a>
33	The Attorney General	Strictly speaking, this was not a request under the FOIA. I asked my local MP, Mr Stephen Williams, to table a written question in parliament to ask the Ministry of Justice for the information described in request #32. Mr Williams tabled the question, but Mr Djanogly declined to provide the information on the basis that 'The information requested is not held by the Ministry of Justice and is not readily available. The cost of collating it would be disproportionate, as such an exercise would require the Official Solicitor to recover from secure storage all files relating to applications to the Court of Protection (other than those relating solely to Property and Affairs) and to then trawl through them for the relevant information to be obtained.'	09-May-11	09-May-11	<a href="http://www.publications.parliament.uk/pa/cm201011/cmhansrd/cm110509/text/110509w0001.htm">http://www.publications.parliament.uk/pa/cm201011/cmhansrd/cm110509/text/110509w0001.htm</a>

# APPENDIX B – SUPPLEMENTARY MATERIALS ON REGULATION AND OMBUDSMEN

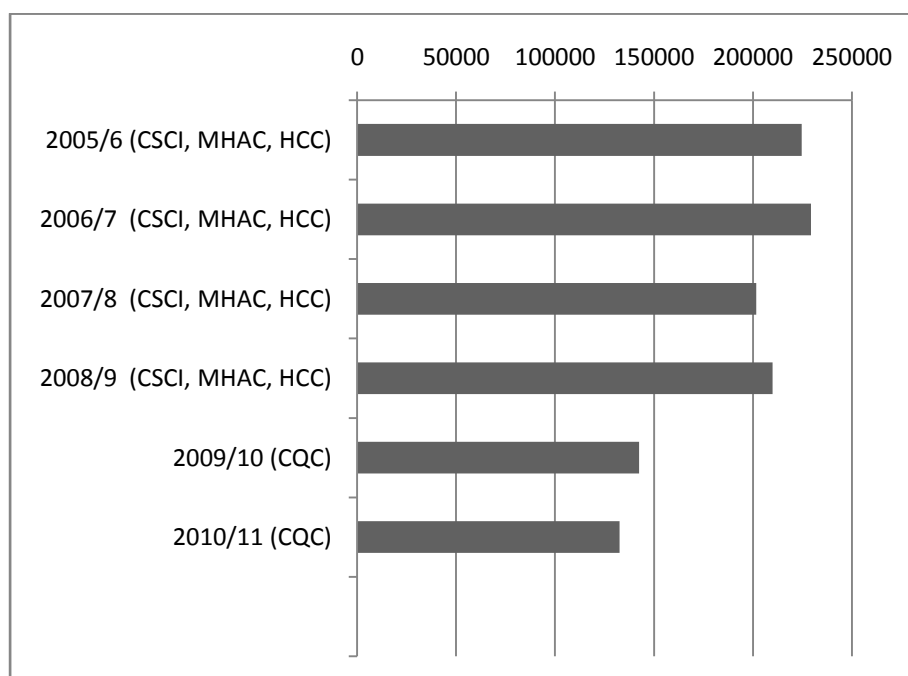
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This appendix supplements discussions of regulatory approaches to the enforcement of the Mental Capacity Act 2005 (MCA) and the deprivation of liberty safeguards (DoLS) in the body of this thesis. It contains details of data gathered under the FOIA, or combined in new ways from other sources. It includes several small studies which sampled CQC's regulatory reports, and summaries of reports by Ombudsmen discussed in this thesis.

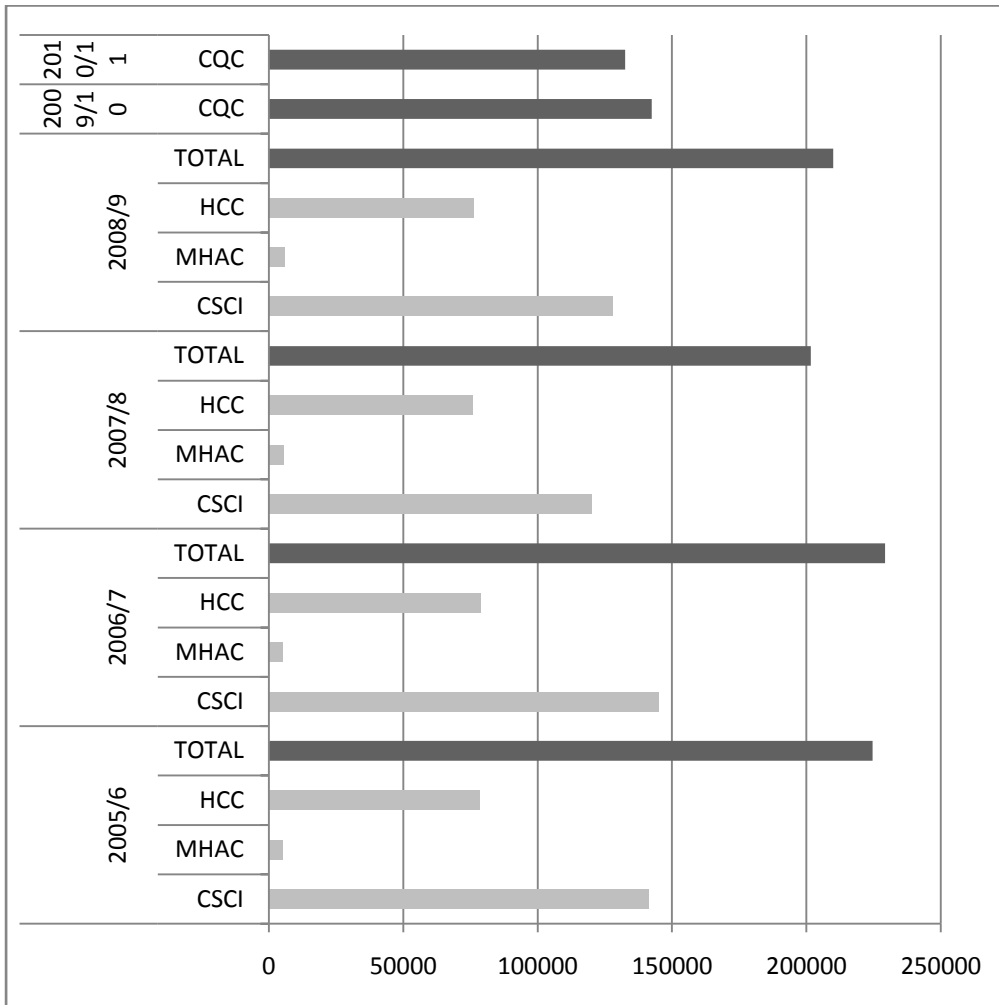
## STUDY B1: INCOME AND EXPENDITURE OF CQC AND PREDECESSOR BODIES, 2005-2011

Data source: Data supplied by CQC under the FOIA (FOIA #6). Annual reports of the predecessor commissions (Mental Health Act Commission, 2007; 2008a; 2009a; Healthcare Commission, 2007a; 2008).

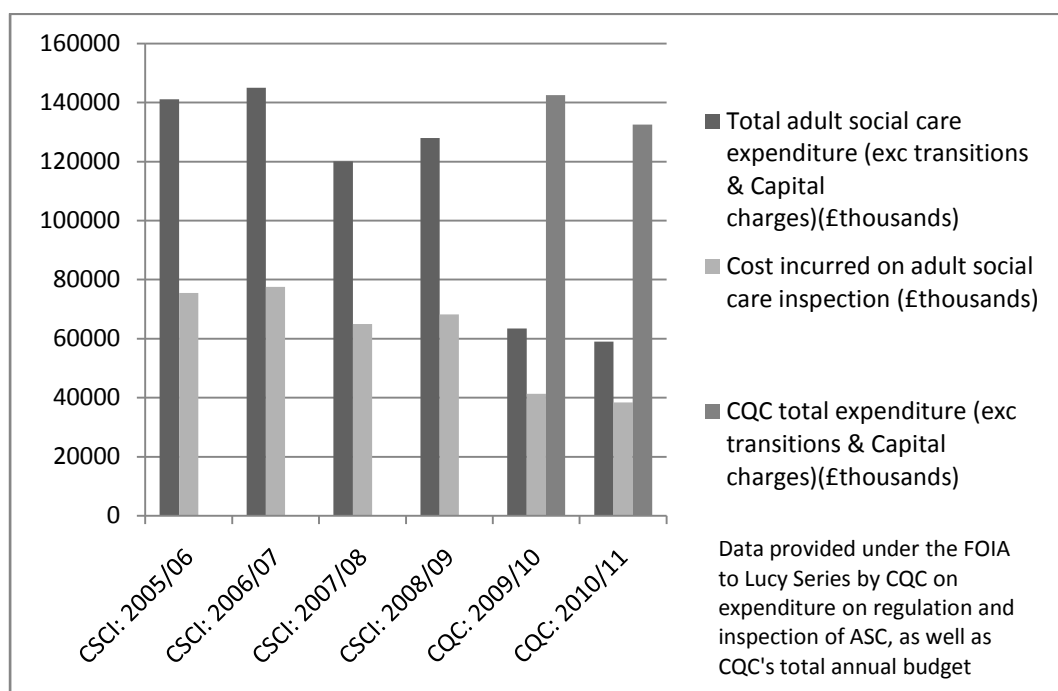
**Figure 7 Total combined expenditure on regulation of health and social care, and Mental Health Act visitation (£000)**



**Figure 8 Annual expenditure of CQC and its three predecessor commissions (£000), 2005-2011**



**Figure 9 Expenditure on regulation and inspection for adult social care, 2005-2011**



## STUDY B2: CSCI AND CQC INSPECTION REPORTS

As outlined in Chapters 2 and 3, it is expected that health and social care regulators will contribute towards the protection of legal rights of social care service users through enforcement of the principles of the HRA, the MCA and other legislation. Inspection reports for Cornish residential care services for people with learning disabilities were examined for mentions of key terms linked to the MCA and the HRA.

### SAMPLE

30 inspection reports were downloaded from the CQC's website in July 2012. These reports were identified by using the CQC's search engine<sup>920</sup> and selecting the first 30 services that came up for a search of care homes for 'Cornwall' with the 'learning disability' option selected for which there was a report. A sample of 30 was chosen as it was felt that it would be sufficient to demonstrate whether or not inspectors in that area were routinely making reference to matters connected with the MCA and various key connected issues. The sample was not intended to exhaustively cover all the sub-categories of issues connected with the MCA, and so data saturation techniques were not employed (Guest et al., 2006).

Finding 30 reports required a search of 36 services, as 6 did not have inspection reports available online at all. For eight of the services there was no inspection report by

<sup>920</sup> www.cqc.org.uk

the CQC, so a CSCI report was used. The table below shows the properties of the reports in terms of compliance, and the period since the inspection the most recent report for that service is based upon.

**Table 3 Properties of CQC and CSCI inspection report sample**

	Number	%
Number recorded non-compliant	3	8%
Number of services with no inspection reports online	8	22%
Average (mean) number of months since last inspection	28	
Average (median) number of months since last inspection	32	
Longest period (months) since last inspection	39	
Shortest period (months) since last inspection	1	
Number of services inspected in last 12 months	5	14%
Number of services inspected in last 24 months	7	19%
Number of services inspected in last 36 months	22	61%
Number of services inspected 3 years or longer ago	10	28%

## CODING

The inspection reports were uploaded to qualitative research software package NVivo. The following terms were chosen as a priori themes for coding the reports: advocacy; capacity; choice; consent; deprivation of liberty; dignity; person-centred; privacy; restrictions; restraint; rights; rules and regimes. These terms were selected as they reflect key issues relating to the MCA and associated areas of human rights. Each report was then hand coded against each theme. The key terms were ‘tree nodes’, with various emergent sub-themes for the ways in which these concepts appeared in the inspection reports. The number of sources (i.e. individual inspection reports) each node appeared in, and the overall number of references for each node, is given in Table 4, below. Sometimes a particular term came up in almost all reports because it was part of CQC’s standard rubric;<sup>921</sup> uses of a term which were not deliberately included by an inspector are excluded. For each category of code, the ‘node’ with the most references is given in bold:

<sup>921</sup> For example, ‘rights’ and ‘choice’ come up as part of the CQC’s rubric explaining what the essential standards are.



**Table 4 Frequency of codes arising in CQC reports for residential care services for people with learning disabilities in Cornwall, by source and reference**

Code category	Node	Sources	Refs
Advocacy	*Concerns about lack of access to advocacy	0	0
	Service praised for involvement or encouragement of advocate	6	11
	Service providers as advocates	1	1
Capacity	Best interests decisions appropriately recorded	1	1
	Capacity assessment needed	1	1
	Capacity Ax seen in care plan	2	2
	Lack of involvement in decision making of people who lack capacity	2	2
	MCA training	8	14
	People assessed by service as having the capacity to consent to use of lap straps	1	1
	Provider has participated in multidisciplinary best interests meeting	1	1
	Restriction of a person with diminished "cognitive capacity" observed	1	1
	Staff demonstrated 'awareness' of MCA	2	2
	No recording of best interests decisions in lieu of consent	2	5
Choice	Care plan includes restrictions on choice and freedoms	2	2
	Choice given as reason for not changing smelly furnishings	1	1
	Choice in furnishings	3	3
	Choice of activity	7	9
	Choice of food	7	10
	Choice of format of care plan	1	2
	Choices around admission	3	6
	Evidence of support to make decisions	1	3
	Good choice practice	3	3
	Poor choice practice observed	2	5
	Potential restriction the result of choice	1	1
Consent	*Concerns about consent and medication	0	0
	Concerns about consent and support	2	3
	Consent to care recorded in care plan	2	4
	Consent to involvement of family or advocate	1	1
	Good consent practice	1	2
	Misunderstanding of consent	1	2
	Provider has policies on consent	1	1

Deprivation of liberty	DOLS referral made	1	1
	DOLS referral not made but should have been	1	1
	DoLS training	5	7
	Nobody currently subject to DOLS	1	1
	Requirement made about restrictions on liberty	1	1
	Staff show awareness of DOLS	1	1
Dignity	Care plan covers dignity	1	1
	Concerns about dignity	2	4
	Dignity included in statement of purpose or service policy	2	3
	Dignity is respected in service	2	2
	Environment needs improvement to promote dignity	2	5
	Staff observed treating residents with dignity	6	7
	Staff say they provide care with dignity	1	1
	Storage of personal information must not compromise dignity	2	6
Person-centred	Evidence of non-person centred care	1	2
	Participation in service delivery	1	1
	PCP training	1	1
	Personalised room	5	6
	Person-centred or individualised plans viewed by inspector	7	11
	Service says it uses person-centred approaches	2	3
	Treated as an individual	1	1
Privacy	Concerns about privacy	1	1
	Evidence of privacy being respected observed by inspector	3	3
Restrictions	Child gate used	1	1
	Concerns about restrictions	2	4
	Requirement made concerning restriction on liberty	1	1
	Restraint	3	3
	Restrictions appear appropriate	1	1
	Restrictions are recorded	4	4
	Restrictions not agreed in care plan	1	1
	Restrictions on consumption of food or drink	2	4
	Restrictions on visitors	1	1
	*Seclusion	0	0
Some restrictions on access to hazardous areas	1	1	

	Staff show awareness of restrictions linked to DOLS	1	1
	Window not fitted with restrictors	1	1
	Windows fitted with restrictors	1	1
Rights	Rights mentioned in care plan	1	1
	Rights mentioned in statement of purpose or policy documents	1	1
	Inspector expresses concerns about rights of residents	2	8
	Service users informed of 'rights and responsibilities'	3	3
	Service users' rights are respected	2	2
	Staff have been on human rights training	1	1
	Staff promote service users' rights and choices	1	1
	Staff say they promote people's rights	2	2
	Voting rights	2	3
Rules and regimes	The service operates a 'no alcohol' policy	1	1
	Service users report not having to ask permission to make a cup of tea	2	2
	Service users report being allowed to manage their own money	1	1

## DISCUSSION

The sample was adequate to show that whilst CQC inspectors do make frequent reference to the MCA and related concepts. Most references are related to recorded information, especially information connected with training and care plans, but some inspectors also sometimes record their own observations and interactions with service users. Such observations occurred less frequently, however, than references to recorded information.

These data suggest that MCA inspectors do monitor the MCA and related issues on a fairly frequent basis, but not routinely for all services. There was a greater tendency to report that an inspector had seen a capacity assessment or evidence of training on the MCA or the DoLS, than to raise concerns about the absence of an assessment or training, etc. The absence of routine mention of capacity assessments, bests interests decisions, DoLS referrals, and training on these schemas may mean that that CQC inspectors are not routinely be considering these issues. There is a danger that inspectors simply report what they are shown and told, rather than routinely probing for evidence in each area.

## STUDY B3: THE VOICE OF SERVICE USERS

CQC reports on adult social care services contain a section entitled 'What people say about this service'. This small study examined how reliably these sections are completed by inspectors visiting learning disabilities residential care services, and offer a sample of the kinds of things they reported. The study examined reports from two areas, and included compliant and non-compliant services.

### SAMPLE

Within the time constraints of this doctoral research it was not practical to conduct a large survey of CQC inspection reports. To pick up on possible differences between inspectors from different regions, I chose two separate postcodes – one being rural, and one being urban. Using the CQC's search engine, I searched for learning disabilities residential care services in those areas, and picked the first ten compliant and the first ten non-compliant services for each. Searches were conducted in November 2011.

### RESULTS

Table 5 shows, for each area and for compliant and non-compliant services, whether or not a report was available on the website; whether or not the report recorded that inspectors spoke to residents; whether CQC inspectors spoke with relatives or advocates of residents; and whether or not CQC inspectors observed interactions between residents and staff.

**Table 5 Methods used by CQC inspectors to examine the experiences of care home residents**

Area	1 (Rural)		2 (Urban)		Totals
	Compliant	Non-compliant	Compliant	Non-compliant	
Reports available (of a possible 10)	2/10	8/10	2/10	9/10	21/40
Inspector spoke with service users (of number of reports)	1/2	8/8	0/2	4/9	13/21
Inspector observed interactions between staff and service users	1/2	3/8	1/2	1/9	6/21
Inspector spoke with relatives or advocates of service users	0/2	1/8	2/2	3/9	6/21

Inspector did not speak with residents, their relatives or their advocates	1/2	1/8	0/2	4/9	6/21
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## DISCUSSION

Online inspection reports were unavailable for almost half of services when this study was conducted; reports were more likely to be available for services which were non-compliant with CQC's regulatory standards. For those services for which reports were available, inspectors spoke to service users in 61% of services, they spoke with relatives or advocates of service users in 29%, observed interactions between staff and service users in 29% and did not speak with residents, their relatives or their advocates in a residual 29% of services.

For most of the reports where inspectors did not speak with service users, the reason for not speaking with them is not recorded. One report states that the 'the level of their learning disability' was a reason for not talking to service users, but states that inspectors contacted a relative to seek their views instead. Other reports stated:

'People living in [the service] have a learning and physical disability and use non verbal communication to communicate their needs. This made it difficult to fully gain the views of the people who use the service.'

'The individuals living at [the service] have a learning disability and complex needs which meant that it was difficult to seek their views as many of the individuals used non verbal communication. However, those that could let us know told us they were happy living in the home.'

'During our visit to [the service] we were able to talk with one person who lives there. The other people were not able to communicate extensively, but we were able to get some useful information and views from another person. We also talked to the relative of one person who lived at [the service] by telephone.'

'We spoke with 4 people who use the service and they told us that they were happy living [there] and said that they were treated well. We were unable to speak with other people due to the nature of their learning disability. We did speak to family members and they told us that their relatives are supported by the staff to receive the care they need.'

'We were unable to talk to people about the outcomes we assessed and obtain a detailed view about what it is like living at [the service] due to the level of their learning disability'

In that last service, inspectors relied upon observations of how staff and residents interacted in lieu of talking to residents.

In almost all reports residents were reported as being complementary about the service, however a few were not:

'We spoke to three people living in the home but we received few comments about their lives at the home. Some of the comments we received were positive and others were not and we have raised these with the local safeguarding team... Since our site visit the provider has agreed to suspend all admissions to the home for the time being.'

'We were only able to speak to 2 people during the visit and received limited information from them. We also spoke to social services who have recently investigated an allegation that a staff member shouted at someone living at the home. This allegation could not be substantiated and social services told us that the service is meeting people's needs. People told us that they are happy living at the service and that the staff treat them well.'

#### COMMENT

This study suggests that in November 2011 no online reports of inspections were available for a large proportion of learning disability services in these areas. This may relate to problems with the CQC's website, and not the existence of such reports. Of those reports that were available, it appears that inspectors are not always able to seek the views of service users. In some cases this is described as being because of the level of the service users' disability. A lack of specialist knowledge of their communication method on the part of the inspector might contribute towards this inability to communicate, but this is not discussed in the reports. In some cases, inspectors compensated for an inability to communicate with residents by seeking the views of relatives or advocates; however the means by which those relatives were selected and approached is unclear. They may have been chosen by the service, which might result in a more complimentary sample than might have been achieved through random selection.

Some inspectors relied upon observation of staff-resident interactions. In some cases, inspectors were able to only obtain limited information from service users, although no reflections on why that might be the case are offered in the reports. In several cases neither the service user nor their advocates or relatives are spoken with by inspectors, and no reason is given by the author of the report for this shortcoming.

#### STUDY B4: ENFORCEMENT ACTION TAKEN BY CQC

CQC has statutory powers to take enforcement action against health and social care services who do not comply with their essential standards. CQC supplied the following information about the number of times they had taken different kinds of

enforcement action against different kinds of providers (FOIA #9). Information is for the period April 2010 – February 2012 for the NHS and October 2010 and February 2012 for the other sectors.

**Table 6 Enforcement actions by CQC, 2010-2012**

	Social Care Organisation	Independent Healthcare Organisation	NHS Healthcare Organisation	Total
Warning notice	487	17	14	518
Cancellation of registration	15			15
Impose a condition	18			18
Suspension of registration	3			3
Urgent imposing condition		1		1
Fixed penalty notice	1			1
Vary a condition	12			12
Prosecution	1			1
Simple caution	3			3

In response to a further question about how often enforcement activities related to different essential standards, CQC provided this data for April 2010-March 2011:

**Table 7 Compliance actions undertaken by CQC for different essential standards, 2010-2011**

Essential standard	Type of compliance action	Number of actions
4: Care and welfare of people who use services	Impose a condition	2
	Warning notice	3
7: Safeguarding people who use services from abuse	Warning notice	2
9: Management of medicines	Warning notice	3
12: Requirements relating to workers	Warning notice	1
16: Assessing and monitoring the quality of service provision	Warning notice	1

## STUDY B5: LOCAL GOVERNMENT OMBUDSMAN REPORTS ON CAPACITY

The Local Government Ombudsman (LGO) investigates complaints into local authorities and care providers. A site search of the LGO website<sup>922</sup> produced several investigation reports which referenced the MCA or associated terms such as 'capacity', 'best interests' and 'consent'. The search is not exhaustive as many LGO investigations are not published, however the results give a flavour of the LGO's approach to issues around capacity and consent. A summary of the reports, and their relationship to capacity, are as follows:

### ***Bristol City Council 2011 (09/005/944):***

Mrs Johnson, an elderly lady with dementia, was resident in a care home rated 'poor' by the CSCI/CQC. A CQC inspection found that residents were being raised as early as 5.30am, were not being assisted by staff when they wanted to be, and were being left wet or soiled, unattended and at risk. The placement was partially funded by the council. After a 'safeguarding' investigation by the council, Mrs Johnson was moved to a different 'Unit' operated by the provider; her family were not informed of the move. Following a 'particularly appalling incident' Mrs Johnson's son sought to move her to an alternative care home which cost more, believing he must pay a third party contribution towards the cost.

Mr Johnson complained to the council, who concluded that Mrs Johnson's personal care needs had not been met for several months, but concluded they had taken appropriate action to safeguard her. The LGO found Maladministration. It held that whilst the Council's investigation had attributed responsibility for poor care standards to the provider, 'As the commissioner of the service that Mrs Johnson received... the Council was responsible for the poor service received.' Citing s6 HRA and positive obligations arising under Article 3 ECHR, the LGO noted that social services 'are obliged to use their powers to protect vulnerable adults from abuse'. The investigation found that the Council did not carry out a mental capacity assessment when it moved Mrs Johnson to a different unit. It stated 'Councils should take their responsibilities under The Mental Capacity Act seriously... the Council's actions critically overlooked the rights of Mrs Johnson to have her individual needs considered, it denied the family the opportunity to make best interest representations on her behalf at the earliest opportunity and overlooked considering whether advocates should have been involved... This too amounted to maladministration.'

### ***Bolton Metropolitan Borough Council 2004 (02/C/17068):***

Mrs Jefferson complained that the Council had failed to find a suitable placement for her son, Andrew Taylor,<sup>923</sup> after a Mental Health Tribunal

<sup>922</sup> A site search using Google ("site:www.lgo.org.uk") was used on the recommendation of the LGO as there is a current problem with their internal search engine for searching reports.

<sup>923</sup> Not their real names



had found that he should be transferred out of a secure adult psychiatric ward to an appropriate placement as soon as possible. Mr Taylor had epilepsy and Fragile X Syndrome; his mother claimed that 'there were no facilities in the hospital for patients with a learning disability, staff were not familiar with the needs of people with an autistic spectrum disorder, her son was constantly heavily sedated and his right to liberty was violated.' The LGO found 'a catalogue of errors', including failure to properly conduct a community care assessment and to prepare him for a return to the community from a special school.

Mr Taylor had been sectioned shortly after returning from the special school because of his behaviour and, according to the LGO, 'because of the Council's refusal to fund a placement that would have met his needs, he remained for 18 months in a locked adult psychiatric ward whose provision was totally unsuitable.' The prioritising of budgetary considerations prolonged his detention in hospital. The LGO found Maladministration. The case occurred before the MCA was passed, and capacity is not mentioned, but the report does cite Articles 5 and 8 ECHR, and point towards the important role of local authority social services in obviating the need for detention in hospital.

#### **Leeds City Council 2011 (10/012/561)**

Ms B was estranged from her mother, but learned that she was in a care home and unlikely to live long, and sought to visit her. Ms B's brother made allegations to the care home and the Council that a visit from Ms B would upset his mother. The care home told Ms B she was not permitted to visit. The Council officer was told by a service manager to assess Ms B's mothers' capacity to make a decision about the visit; as the officer had felt unable to personally assess her capacity she had made an urgent referral to an IMCA to conduct the assessment. The referral took several weeks, and by the time it was completed Ms B's mother had had a stroke and was no longer able to recognise or communicate with her daughter.

The LGO found maladministration which 'deprived Ms B and her mother of the opportunity to speak with each other before they were separated forever by death.' The LGO noted that capacity assessments are usually conducted by the person who must make a decision on somebody's behalf, although specialists can be used for more formal assessments.<sup>924</sup> It also noted that the purpose of an IMCA 'is to help particularly vulnerable people who lack the capacity to make important decisions'. Having cited Article 8 ECHR, the LGO stated 'Relatives and friends have the right to visit and see each other without undue interference and the right to respect for family life is enshrined in law.' The LGO found it was maladministration to prevent Ms B from visiting the home. It commented 'It is no mitigation to say that the delay in arranging to assess Mrs B was because the Mental Capacity Act was new – there was no need for a 'specialist' assessment.'

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<sup>924</sup> In fact, although a specialist such as a doctor may conduct a formal assessment, it is still the responsibility of the person making the substituted decision to use this as evidence to come to their own assessment. Legal responsibility for assessing capacity cannot be delegated, although evidence to assist with assessment can be sought.

## **Local Government Ombudsman, 'Manchester City Council Annual Review: 2010'**

The review described a case where a complainant to the LGO suffered noise nuisance from a neighbour who had 'significant mental health problems'. The LGO criticised the council for not having a protocol with the mental health trust who supported the neighbour, for delaying taking possession proceedings in relation to the neighbour and not encouraging the housing trust to take such action. The LGO 'considered that the council was preoccupied with the neighbour's mental capacity when this was a matter for the Court and this contributed to the delay in taking action.'

## **Northumberland, Tyne and Wear NHS Foundation Trust and Newcastle City Council 2011 (08/003/256) A joint investigation by the HSO and LGO<sup>925</sup>**

Mr J was an 'active, outgoing and sociable man' with Down's Syndrome who lived independently in rented accommodation with his wife with local authority arranged support from The Coquet Trust. He was admitted to hospital for a 5-6 week assessment owing to concerns about his declining health and skills, but remained in hospital for seven months, including five months where he was declared fit for discharge. When he was discharged it was into 'inappropriate locked accommodation'. He remained in that accommodation until he died, ten months later. The complaint was brought by Mr J's brother.

The Ombudsmen found that the NHS trust should have documented their view of Mr J's capacity to consent to admission to hospital, and continued to review his capacity to consent to inpatient status during the following months 'in line with the guidance issued following the Bournemouth case'.<sup>926</sup> The NHS Trust contended that Mr J was happy in the hospital and made no attempt to leave; this was disputed by his brother and the Ombudsmen pointed out that in any case 'the fact that an individual might not have tried to leave did not mean they were not being 'detained''.<sup>927</sup> The Ombudsmen observed that the NHS Trust 'had clearly given Mr J and his family the impression that only they (the NHS Trust) could say when Mr J could leave the hospital',<sup>928</sup> and had failed to involve his family appropriately in care planning or to 'to appreciate the full importance of Mr J's family in his life'.<sup>929</sup> The Council were criticised for failing to support Mr J's wife to visit him more than once a week,<sup>930</sup> and for the 'astonishing and absurd'<sup>931</sup> situation that in order to secure appropriate housing in order to leave hospital, Mr J was expected to use a choice-bidding system which required him or a nominated person to bid for advertised properties. This system was not explained to his family, no relative or professional were invited to bid on his behalf, and two offers that were eventually made

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<sup>925</sup> Also published as: Local Government Ombudsman and Parliamentary and Health Service Ombudsman (2011).

<sup>926</sup> Ibid, [88]

<sup>927</sup> Ibid, [89]

<sup>928</sup> Ibid, [90]

<sup>929</sup> Ibid, [92]-[93]

<sup>930</sup> Ibid, [97]

<sup>931</sup> Ibid, [100]

were refused without any consultation with either Mr J or his family – after which no further offers were forthcoming.

The council attributed the lack of further offers to Mr J's failure to bid, a response which the Ombudsmen found 'outrageous and indefensible. It entirely ignores the question of Mr J's capacity to act on his own behalf'.<sup>932</sup> They concluded that 'the Council's failure to review regularly and record why Mr J was being effectively detained in unsuitable, locked accommodation, and their failure to take appropriate and urgent action to find suitable permanent accommodation, were so serious as to amount to service failure'.<sup>933</sup> They wrote 'in failing to take timely and appropriate action to find permanent suitable accommodation for Mr J and his wife, the Council were not just failing to act in Mr J's best interests, but failing to ensure that Mr J's human rights were adequately safeguarded'.<sup>934</sup> The Ombudsmen did not, however, uphold complaints against the care provider, on the basis that 'it seems to us that Coquet Trust staff did what was reasonably possible within the time allocated to them'.<sup>935</sup>

### **North Yorkshire County Council 2005 (04/C/06322)**

Mrs Talbot complained that the Council failed to ensure that her brother, Mr Mitchell, received adequate care. Mr Mitchell had Multiple Sclerosis, heart disease and eczema, and lived alone. Following an assessment, home care was arranged. Home care workers expressed concern about Mr Mitchell's relationship with a woman whom they said drank excessively. His sister became more concerned about his care, and desired a multidisciplinary meeting to discuss this. A Council officer did not arrange such a meeting as 'He did not want people having discussions about him and she would not arrange such a meeting without his consent'. Mrs Talbot investigated residential care options for her brother, and in a meeting with a consultant Mr Mitchell apparently agreed that he needed to be in such a setting. Mrs Talbot informed the Council officer that Mr Mitchell's GP and consultant support supported such a move, but the officer doubted the Council would fund such a placement and did not contact them. The officer reported that Mr Mitchell told her he did not wish to move into residential care or leave the town where he lived. The officer eventually sought a medical and mental health assessment from Mr Mitchell's GP, but he died before it was arranged.

The LGO criticised the Council for failing to communicate to Mrs Talbot that a multidisciplinary meeting did not take place because it was not what Mr Mitchell wanted, and for failing to obtain information from Mr Mitchell's GP or conduct a proper review. However, Mrs Talbot's complaint about the reluctance of the Council not to pursue residential care options was not upheld, stating 'I appreciate that she believes that gentle persuasion by the Council would have brought him round to the idea of residential care but the evidence suggests he was resistant to this and there is no evidence that he was incapable of making such decisions for himself.' According to the LGO, the council had not got the wrong balance between

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<sup>932</sup> Ibid, [102]

<sup>933</sup> Ibid, [103]

<sup>934</sup> Ibid, [105]

<sup>935</sup> Ibid, [106]

'his wishes and the risk that he was prepared to take in his own care arrangements with his sister's understandable wish to protect him.' The LGO's report does not explicitly mention mental capacity (although it does talk about 'capability'), best interests or the MCA, which had been passed in April that year although it had not come into force.

**St Helens Metropolitan Borough Council and 5 Boroughs Partnership NHS Trust 2011 (Parliamentary and Health Service Ombudsman and Local Government Association, 2011)**

Mr B lived independently in the community and 'had a long history of involvement with mental health services' including detention under the MHA and suicide attempts. He received support from cleaners, a support worker and a care co-ordinator, who was a community psychiatric nurse and who administered medication to him fortnightly. Mr B's cousin had attempted to alert the NHS Trust and the Council to concerns about hygiene and Mr B's health. He was eventually admitted to hospital with malnutrition, dehydration and was eventually diagnosed with a bone marrow cancer which led to his death. Mr B's cousin complained that a psychiatrist had prescribed inappropriate drugs for depression instead of responding to his poor physical state; that he had not been supported to claim appropriate welfare benefits; care plans were not implemented; no one responded appropriately to developing risks to his physical and mental health; and that consequently he had 'lived in squalor and pain' and been admitted to hospital too late for treatment for his cancer to extend his life. The Ombudsmen did not uphold the complaints regarding the psychiatrist or support to claim benefits, however they found that 'the Trust and the Council had failed in their joint responsibility to manage and implement Mr B's care plans and to take adequate account of developing signs that he was at risk.'

The Ombudsmen explicitly considered the MCA, which they described as 'a statutory framework to empower and protect vulnerable people who are not able to make their own decisions'. The Council and the Trust had denied fault, stating that 'Mr B was a long standing, voluntary patient with capacity, entitled to reject assistance, which he did.' The Ombudsmen were critical that 'There seemed to have been an assumption that Mr B had at all times the capacity to make decisions in relation to his day-to-day life', without his capacity being formally 'tested'. A nursing adviser who advised the Ombudsmen described care workers as 'working in a culture which emphasised the individual's right to live in the way they chose', and the community mental health services team were described elsewhere as having 'a strong sense that people had a right to live in the way they chose.' They commented that although concerns had been raised about Mr B's capacity, they were never pursued within the framework of the MCA, and concluded 'The reality was that whereas Mr B might have been able to choose what he wanted to eat from a menu when in hospital, his mental state meant that he could not prioritise his physical needs against, for example, his desire to buy children's toys.' The nursing adviser recommended the use of guardianship<sup>936</sup> to enable care workers to be more 'assertive' about access for cleaners and to ensure 'that Mr had access to basic appliances such as a telephone, cooker and washing

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<sup>936</sup> Presumably under s7 MHA

machine.<sup>937</sup> The LGO observed that although the community mental health team had a good understanding of the MHA, it 'did not always consider the potential to use the Mental Capacity Act 2005 when the threshold for use of the Mental Health Act 1983 was not met', and community psychiatric nurses tended to think that capacity had to be assessed by a psychiatrist.

#### **Torbay Council 2012 (10/002/564)**

Mr Castle<sup>938</sup> issued a complaint against Torbay Council for issuing bankruptcy proceedings against him for a council tax debt of £2,248 without having proper regard to his personal circumstances, including his mental health. Mr Castle lived alone, and – having been made redundant – lived off savings and income from his band. In 2006 he followed a 'a gradual descent into chronic introspection' and 'mental instability'; he ceased opening letters, and 'used the back door to access the property and stayed out of sight if callers came.' Bailiffs sent by the council were unable to gain access to the property, and reported to the council the accumulated post on the doormat and cobwebs over the door. Feeling that Mr Castle would not respond to committal proceedings, the Council initiated bankruptcy proceedings to recover the debt. The man who served the bankruptcy petition on Mr Castle, 'had some doubts' about him and was unable to 'reach a view on whether Mr Castle was being evasive or was in fact suffering illness.' A bailiff recalled that Mr Castle was suicidal, and a note on a Council solicitors' file noted concerns about his mental health. The Council established that social services had no record of contact with Mr Castle,<sup>939</sup> and made an appointment for him with the Citizen's Advice Bureau. A bankruptcy order was made, of which Mr Castle became aware when he was visited by the trustee in bankruptcy. Mr Castle took out a loan against his property and cleared the £2,248 debt to the Council and a £3,940.99 debt to a utilities company, but incurred additional costs of £24,000 due to the bankruptcy action.

The LGO found in an earlier report that 'the Council was at fault in failing to conduct and document a full review of the case in light of the information it received that Mr Castle was possibly suicidal' and recommended compensation of £25,000. The Council refused to pay this compensation, stating that 'he made a considered decision not to pay his council tax and that this is evidenced by his statement more than a year after the bankruptcy proceedings that he left unopened mail on the floor to give the impression nobody was at home.' The LGO countered that 'There is no evidence that Mr Castle was capable of dealing with his own affairs at the time of the recovery action or that bankruptcy was a considered decision taken in the knowledge of potential mental illness after the due weighing of all pertinent facts.' The LGO noted that it was not the investigator's role to assess Mr Castle's capacity under the MCA, but commented that 'he was not dealing with his affairs at all' and that

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<sup>937</sup> Requiring access to 'basic appliances' is not one of the essential powers under guardianship, although perhaps it is considered an implied power if access is required for persons to install such equipment.

<sup>938</sup> Not his real name

<sup>939</sup> There is no record of whether the social services department followed this up with a community care assessment, as would have been required under s27 NHS and Community Care Act 1990 if it appeared to the Council that he suffered from any mental disability.

despite concerns that Council did not 'take steps to establish evidence of capacity.' The Council argued that in the absence of evidence on incapacity it was duty bound to recover the debt, but the LGO responded that given the information the Council did have a failure to reconsider bankruptcy proceedings amounted to maladministration; it reiterated its call for compensation.

#### **Trafford Metropolitan Borough Council 2006 (04/C/17057)**

Mrs Walker signed an application for a renovation grant for her home, which had been declared unfit to live in by the Council, whilst she was detained in a psychiatric hospital. The Council could require repayment of the grant if the home was sold within five years of taking it out; it had previously been three years but the law had changed. When Mrs Walker came to sell her home, her daughter believed that as three years had expired the grant would not have to be repaid, however due to the legal change the Council sought to recover the grant. Mrs Walker's daughter requested that the Council exercise its discretion not to require repayment of the grant. The social worker who had taken the application form to Mrs Walker in hospital could not recall the visit, nor explaining the extended repayment period to her. The Council stated that Mrs Walker had signed the forms during a period of lucidity, but it was unable to provide records to support that. The Council said it was the social worker's responsibility to ensure she was capable of understanding the form, but the social worker said that although she might have understood the information, even when she was well 'she would have been unable to retain information and use it.'

The LGO found maladministration by the Council in not ensuring Mrs Walker understood the extended repayment period, by officers always recommending that the discretion not to repay the grants is not exercised, and by officers advising Councillors that a person's mental state is not relevant to discretionary waivers of grant repayments. The MCA had not come into force at the time of this report, but the LGO notes 'The fact that Mrs Walker had severely impaired mental capacity to the point of being hospitalised at the time means that the Council should have made particular efforts to ensure that she understood every aspect of what she was agreeing to and signing.'

#### **Worcestershire County Council 2011 (09/013/172)**

Mrs Nash had dementia and lived on her own in her home. Her stepdaughter complained that an in-house home care agency of the Council had failed to provide adequate care, and that the Council had not assessed Mrs Nash's needs after she had been admitted to a residential home for the purpose of such an assessment. Neither had there been an assessment when, subsequently, Mrs Nash had been admitted to hospital after she had over-exercised and over-dressed in hot weather. As a result, her health deteriorated and she was unable to return home and moved into residential care. The LGO found maladministration on the basis that 'The Council failed to carry out adequate risk assessment or care planning; failed to communicate to care workers the limits of Mrs Nash's capacity and care workers in turn failed to bring repeated instances of Mrs Nash placing herself at risk in hot weather to the attention of Council Managers.'

The LGO investigator found that although home care workers and Council officers 'agreed that Mrs Nash lacked insight into her condition' they had not intervened, for example to open a window on a hot day, as 'they had to take into account Mrs Nash's wishes.' The Council expressed concern that such interventions might have increased the chances of care breaking down. In response to a complaint from Mrs Nash's stepdaughter, the head of Adult Social Care had stated that care workers were not in a position to 'force individuals to comply' with requests to dress more appropriately, or empty the fridge of out of date food. The Council later accepted 'a need for the Council to routinely consider the need for capacity and risk assessments as part of the care planning process'. The LGO found that maladministration where 'while it was clearly known to the Council that Mrs Nash lacked capacity always to take decisions in her best interests, the Council did not communicate this to the care workers who would deliver her care.' The LGO concluded that whilst training on capacity was given to Council staff, 'it is worrying that the Council has not reflected sooner upon whether more intervention could have been attempted in this case.'

## STUDY B6: STATISTICS ON USE OF COMPLAINTS PROCEDURES

Data source: For information on complaints to the LGO (FOIA #10). For information on complaints to the Commission for Social Care Inspection (FOIA #11).

**Table 8 Complaints and enquiries about Adult Care Services received by LGO**

	2008/09	2009/10	2010/11	2001/12*
	868			
not assigned		1035	990	250
Council: assessment		1	127	238
Council: care plan			40	77
Council: charging			97	179
Council: DFG			30	80
Council: direct payments		1	40	97
Council: domiciliary care		1	34	64
Council: independent living			11	31
Council: non-regulated provision			7	13
Council: other		2	105	310
Council: other regulated provision			10	10
Council: residential care		1	66	128
Council: safeguarding			45	106
Council: shared lives			3	0
Council: transition from children's services			0	12
Council: transport			3	39

Direct payments: domiciliary care			1	2
Direct payments: independent loving			0	1
Direct payments: other provision			0	2
Direct payments: residential care			2	2
Provider obo council: domiciliary care			18	13
Provider obo council: independent living			4	1
Provider obo council: other provision			2	3
Provider obo council: residential care			45	46
Private: domiciliary care		1	6	15
Private: independent living			1	2
Private: other provision			5	27
Private: residential care			46	84
Private: shared lives			1	0
<b>TOTAL</b>	<b>868</b>	<b>1042</b>	<b>1739</b>	<b>1832</b>
Care provider total**		1	128	191
Local authority total**		6	621	1391

\*Only partial data is available for 2011-12; correct up to February 2012.

\*\*These data are incomplete, as not all complaints about adult care services were 'assigned'.

## STUDY B7: COMPLAINTS TO THE LGO REGARDING THE DEPRIVATION OF LIBERTY SAFEGUARDS

Data source: Reproduced with the kind permission of the Local Government Ombudsman, (FOIA #20).

In response to a request about whether the LGO could investigate complaints and award compensation in connection with the deprivation of liberty safeguards (DoLS) the LGO kindly shared three examples and published the following response:

The LGO cannot generally pursue a complaint where a remedy exists by way of an alternative remedy. Someone arguing that they are being unlawfully deprived of their liberty would have a right to approach the Court of Protection and the availability of that "legal remedy" would take the matter outside the jurisdiction of the Ombudsman. The Ombudsman cannot direct that a Deprivation of Liberty authorisation is flawed and should be terminated, only the Court can do this. If the Court makes such a determination, but awards no compensation [either because it cannot, will not or just forgot to address the issue] it would not be right for



someone to ask the Ombudsman to address the alleged shortcomings in the Court of Protection procedures.

That said, deprivation of liberty issues do fall within the jurisdiction of the Ombudsmen and while the Ombudsmen is not able to bring a deprivation of liberty to an end they are able to consider complaints about how deprivation of liberty has been handled and there is no reason why recommendations should not include payments of compensation although any such recommendations are unlikely to be at the kind of levels courts would operate to.

#### CASE 1 – 10 013 715 (“DOROTHY”)

A case where a DoL application was not made promptly and the care home’s/council’s approach to restrictions placed on the complainant and her mother was flawed.

Dorothy was admitted to a care home in February 2005. Her daughter Melinda kept in touch with her regularly. In May 2008, Melinda raised concerns about Dorothy’s care and a safeguarding investigation resulted. The allegations Melinda made centred around poor manual handling, poor care and bullying by staff. The safeguarding investigation took into account all of the issues around Dorothy’s care which included concerns the care home had about Melinda’s disruptive behaviour when visiting – she would often shout and get angry.

In June 2008, Melinda’s visits to her mother were restricted. This was because the home felt Melinda’s behaviour distressed staff and residents and was detrimental to her mother’s wellbeing. A variety of conditions were imposed at different times (Deprivation of Liberty Safeguards did not come into effect until April 2009).

In April 2009, Melinda raised more complaints with the council about her mother’s care. Another safeguarding investigation ensued which was inconclusive. It was clear the relationship between the staff and Melinda had broken down. In June 2009, Melinda’s solicitors wrote to the council and asked on what basis, in light of the new DOLS legislation and associated Code of Practice, the Council believed it had the authority to prevent Dorothy from moving to a new care home. No response was received. In July 2009, a safeguarding meeting was held in the home and, following that meeting, Melinda said she was prevented from leaving the home by the home manager who was threatening and harassing her. No safeguarding investigation was launched as Melinda was not a vulnerable adult.

In August 2009, the council’s safeguarding advocate raised the possibility that a deprivation of liberty might be occurring in respect of Dorothy. He advised that the council should carry out a mental capacity assessment. A further meeting was held in September 2009 where it was again suggested that a DoL authorisation was required. In

October 2009, the home sought a standard DoL authorisation and granted themselves an urgent authorisation. A standard authorisation was granted in November 2009.

The LGO decided that the original restrictions should have been managed by a suitable risk assessment demonstrating the need for controls and the reasons why. This risk assessment should have been periodically reviewed to ensure the actions were both required and justified as time passed. The home was also criticised for not issuing a formal warning to Melinda before curtailing her visits.

In June 2009, Melinda's solicitors wrote to the supervisory body (the local authority) raising the issue of DoLS but they should have written to the managing authority – the care home – who was responsible for seeking the authorisation. It was a further four months before the local authority advised the manager to seek an authorisation and a further five months before the appropriate request was made.

We concluded the approach taken between June 2008 and October 2009 was flawed. We found fault with both the care home and the council. The council has ultimate responsibility for the care provided to Dorothy as it was funding the placement. It was decided that it should have done more to ensure its own staff and the staff in its contracted services were better trained in such matters. We went on to criticise how the DoL assessments were conducted in this case. This criticism included the best interests assessor determining who would be the most appropriate person to act as the 'relevant persons representative'. However, DoL guidance states that the best interests assessor should first establish whether the relevant person (ie Dorothy) has the capacity to select a representative and, if so, ask her to do so. If the relevant person selects an eligible person, the best interests assessor must recommend that person to the supervisory body for appointment.

It was concluded that certain actions would follow to ensure a robust assessment and proper periodic monitoring of the arrangements in place.

## CASE 2 – 10 010 739 (“MRS JONES”)

A case where the DoL decision taken was not the 'least restrictive' option.

Mrs Jones complained to the LGO about the fact that her sister, Mrs Davies, was not allowed to return home after an admission to hospital. Additionally the council prevented her from moving her sister to another care home of her choosing.

Mrs Davies has a degenerative and congenital condition called Huntingdon's Disease. She was living with and being cared for by her sister until October 2006 when she was admitted to hospital. The admission was triggered by the district nurse finding her on the floor. She was covered in bruises from other falls and had an infection. Mrs Davies told staff on the hospital ward she did not want to return to the care of her sister

Mrs Jones. She told others, however, that she did want to return. A multidisciplinary discharge meeting was held. Mrs Davies' other sister Mrs Weston was asked to attend the meeting as she has power of attorney. It was decided that the flat Mrs Jones lived in was unsuitable and that she was unable to give the level of care required. The option of Mrs Davies returning to the flat with a care package was explored but thought to not be viable. Mrs Davies was admitted to a nursing home.

In early 2007 Mrs Jones was also diagnosed as having Huntingdon's Disease. She was suffering from common complications such as poor grip, reduced mobility, slurred speech and memory difficulties. Doctors also had concerns about impulsivity and lack of judgement. Mrs Jones never accepted that she could not care for her sister Mrs Davies. She was unhappy with the care Mrs Davies received in the nursing home at times. Mrs Jones continued to deteriorate and had problems swallowing. She was reluctant to accept help from social services. The records show that Mrs Davies and Mrs Jones missed each other's company a lot. In 2009 the care home placed restrictions on Mrs Jones visiting following some difficulties between her and the carers. After this she was told she could not visit unaccompanied. Some meetings were held at which Mrs Jones stated that she wanted to live in a care home with her sister.

Mrs Jones moved from her small flat to sheltered accommodation and Mrs Davies was able to visit her there. At this time Mrs Davies began asking to go back and live with Mrs Jones. This resulted in an application for a Deprivation of Liberty authorisation. It was granted as Mrs Davies lacked capacity and Mrs Jones was not up to the challenge of providing the level of care required. In addition, Mrs Davies' needs could not have been met in sheltered and supported living accommodation. Both sisters were upset about the authorisation. An IMCA and People's Voice advocacy group was involved.

Eventually Mrs Jones made a formal complaint to the council about the detention. In its response the council said Mrs Davies needed expert care and Mrs Jones would not be able to provide that. The council also said Mrs Davies was settled now and her consultant's view was that her needs were best met at the care home. The authorisation expired after six months and another was made and granted. In the second authorisation it is noted that both sisters voiced a preference for being together. It was however deemed in Mrs Davies's best interests to remain where she was. The council said it would support the sisters spending as much time together as possible. Mrs Jones condition continued to deteriorate and records indicate that she may need residential care very soon.

The LGO decided that we would have expected the council to assess whether the sisters could live together in a home that could cater for the needs of both. In not

exploring that option the arrangements may not be the least restrictive. The council agreed to a multi-stakeholder meeting to begin the process of dealing with the sisters' assessments and begin planning to accommodate them together for as long as they wish.

### CASE 3 – 10 010 398 (“MISS KERR”)

A report on a case where both local authority and care provider had little understanding of the proper process for getting authorisation.

Please note at time of writing this report has not been published. Some detail may be subject to change by the Ombudsman up until publication date.

Miss Kerr has a condition called hydrocephalus and has developed dementia. Before her admission to residential care Mr Wayne cared for her himself and managed her finances. Shortly after her admission to the care home Mr Wayne started to complain to the Care Quality Commission, the police and the local authority that the care home would not allow him to take Miss Kerr out, they were overdosing her on her prescribed medication and had stolen £3,000 from her account. He also made allegations of abuse and neglect. These issues were looked into by the Council but, other than that the care home had overcharged Miss Kerr (and this had been refunded) the other allegations were unfounded. At the same time the council became increasingly concerned about Mr Wayne's behaviour towards Miss Kerr. He was observed to make her do strenuous exercise and walk her for extended periods of time to get her to reduce weight. He also removed food from her and undertook 'reminiscence therapy' despite not being trained to do so. He made allegations to the police that the home was trying to murder Miss Kerr by overfeeding her.

Multidisciplinary meetings were held to ensure that the care Miss Kerr was receiving, Mr Wayne's involvement and the decisions being taken by everyone were in her best interests. It was agreed that conditions and restrictions be imposed on Mr Wayne. His visits were considered to serve his own interests rather than hers. The care provider said Mr Wayne breached the conditions and the multidisciplinary team concluded that it could no longer be sure that Miss Kerr was benefitting from her contact with Mr Wayne. It was agreed that he would be banned from visiting Miss Kerr. Mr Wayne believed that he was banned because he raised complaints. He said he did not break any conditions he had been informed about. In our findings we did not uphold Mr Wayne's complaint in this regard but we did find fault with the way the council and the provider managed the situation.

The council failed to provide the care home manager with correct advice when she asked if an application should be made for a Deprivation of Liberty authorisation.

The council also decided that an injunction was not necessary to prevent Mr Wayne from seeing Miss Kerr. However, paragraph 8.28 of the Mental Capacity Act 2005 states that a court decision might be appropriate where someone suspects that a person who lacks capacity to make decisions to protect themselves is at risk of harm or abuse from a named individual. The Code of Practice and subsequent cases have reinforced that it is the responsibility of the state, in this instance the council, to bring such, or indeed any unresolved dispute about significant issues to court. This is what should have happened in this case at the time.

The council also failed to consult Mr Wayne in its best interests assessment although it had an obligation to do so. The best interests assessment that was done only considered whether it was in Miss Kerr's best interests to continue to live in the care home. It did not consider the relationship between Mr Wayne and Miss Kerr and the impact of the restrictions/ban.

It was also found that the care home had overcharged Miss Kerr £3,000 and this had been refunded.

The care home manager was also at fault for not making an application to the council for a Deprivation of Liberty authorisation at the time at which it suspected that a DoL may have been taking place. Instead she asked the social worker what she should do and was told it was not applicable. It is for the DoLS team to decide if a DoL is occurring and it should have been asked to assess the situation at the earliest opportunity. The manager should have granted the home a seven-day urgent authorisation and applied for a standard authorisation to be considered which would have allowed an independent assessment to be made.

The council's legal department was also at fault for not pursuing a possible injunction and for not suggesting that the court of protection be involved.

When the LGO received the complaint we sent Letter 1 – letter to managing authority concerning unauthorised deprivation of liberty to the home manager. This still did not trigger the correct response and the home manager argued with us that the council had said it was unnecessary. When the application was finally made it was not done properly. It did not involve Mr Wayne and did not assess the key issue of whether contact with Mr Wayne was in Miss Kerr's best interests.

- In our remedy we asked the care provider to:
- provide training to all of its home managers in Deprivation of Liberty Safeguarding procedures.

We also said the council should:

- apologise to Mr Wayne
- pay him £250 for having to pursue the case
- liaise with the care provider and ensure suitable arrangements are made to prevent any recurrence
- review the practice and training requirements of its other care providers
- review its own staff's learning needs, and
- inform the DoLS team of this report and findings.

# APPENDIX C – SUPPLEMENTARY MATERIALS ON THE MENTAL CAPACITY ACT

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## C1 COURT OF PROTECTION

Data source: Court of Protection reports (Judiciary of England and Wales, 2010; 2011). The MCA regulatory impact assessment anticipated there would be 200 health and welfare cases each year (Department for Constitutional Affairs, 2005: [42]).

**Table 9 Applications, orders and deputies appointed by the Court of Protection, 2007-2010**

	2007 (Oct- Dec)	2008	2009	2010
Property and affairs applications received	3814	18697	17068	18360
Property and affairs orders issued	2153	15269	13641	15534
Health and welfare applications received	39	1164	1531	1283
Health and welfare orders issued	2	140	182	218
Property and affairs deputy appointments	170	8155	9982	9437
Health and welfare deputy appointments	0	83	112	106
Application to discharge deputy (P no longer lacks capacity)				2

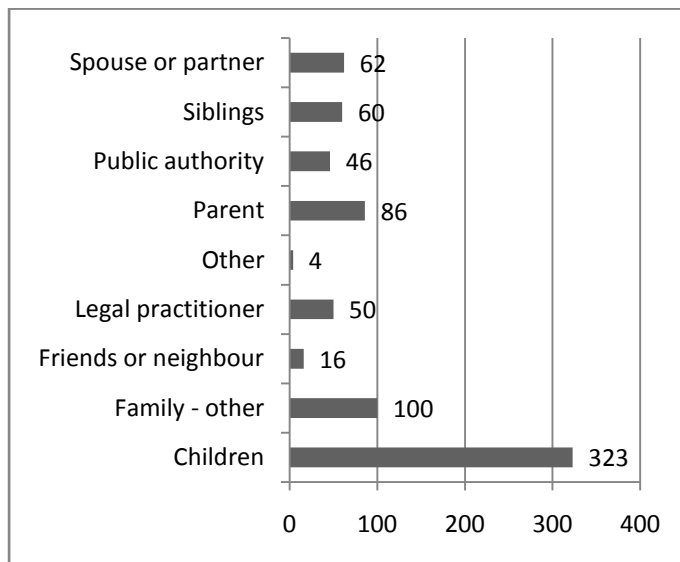
**Table 10 Number of hearings in the Court of Protection, 2009-10**

	2009	2010
Archway	473	473
Regional	783	783

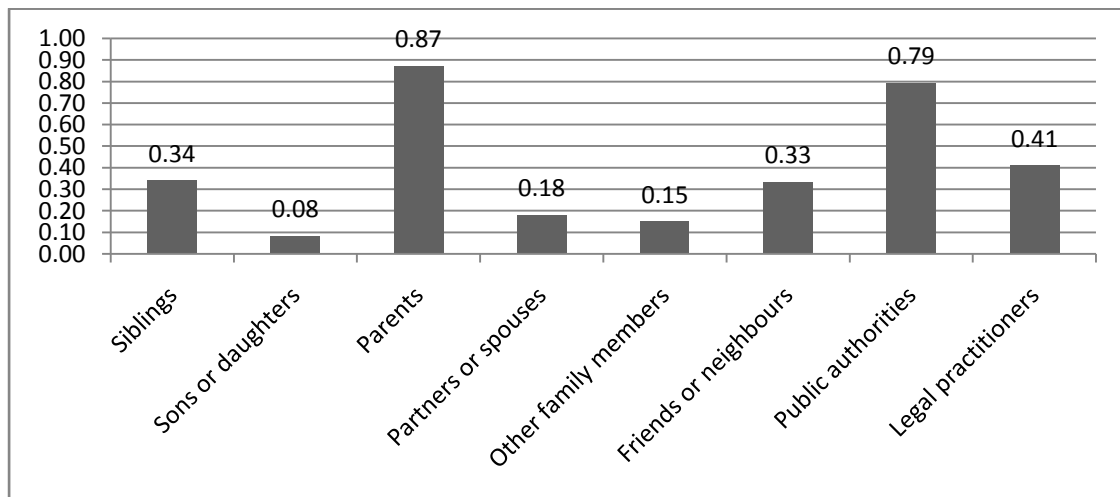
## APPLICATIONS FOR PERMISSION FOR WELFARE MATTERS

Data on applications for permission kindly shared by Senior Judge Lush; graphs reproduced<sup>940</sup> from an article published elsewhere (Series, 2012a).

**Figure 10 Relationship of applicant to P**



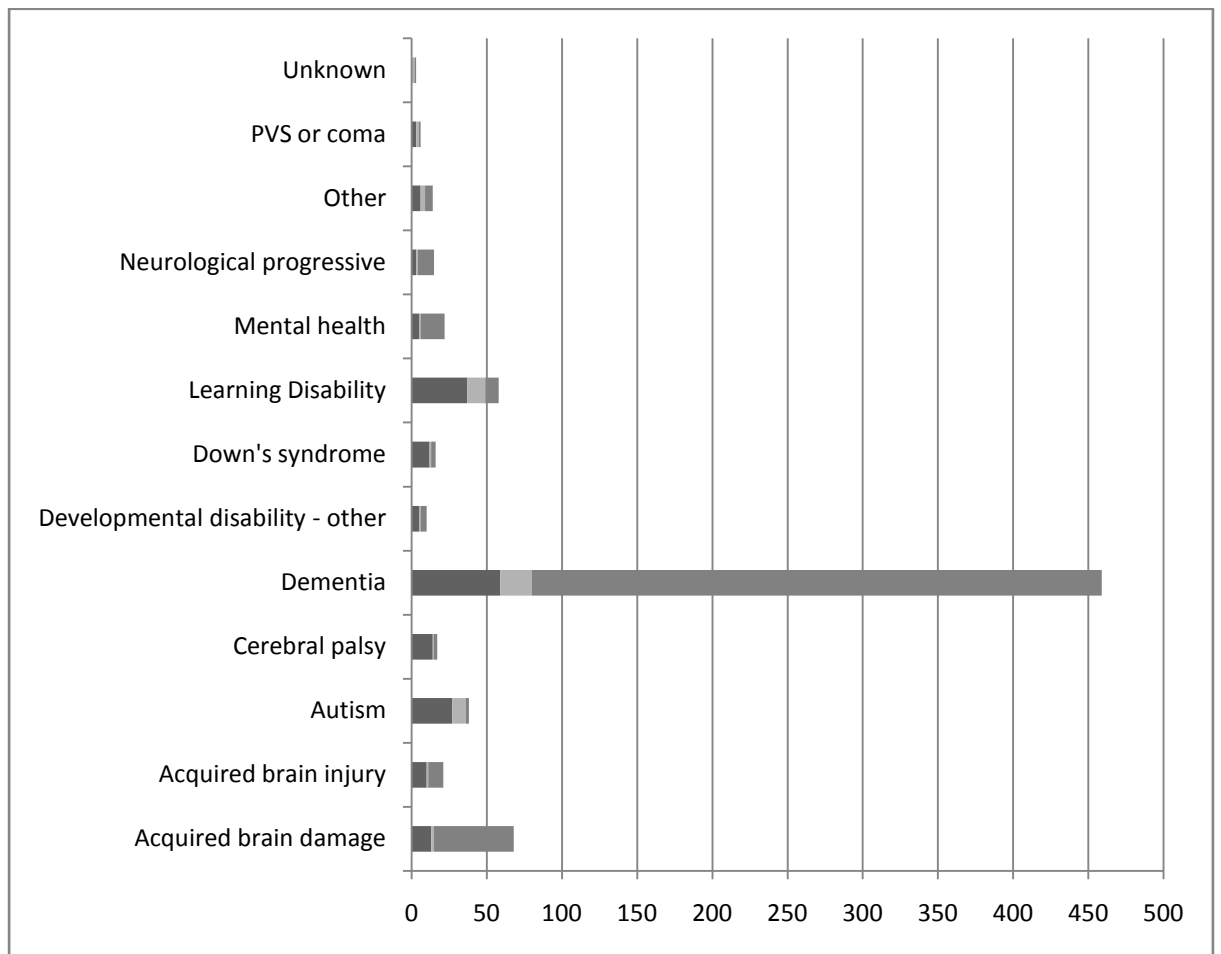
**Figure 11 Success rates of applications for permission by relationship of applicant to P**



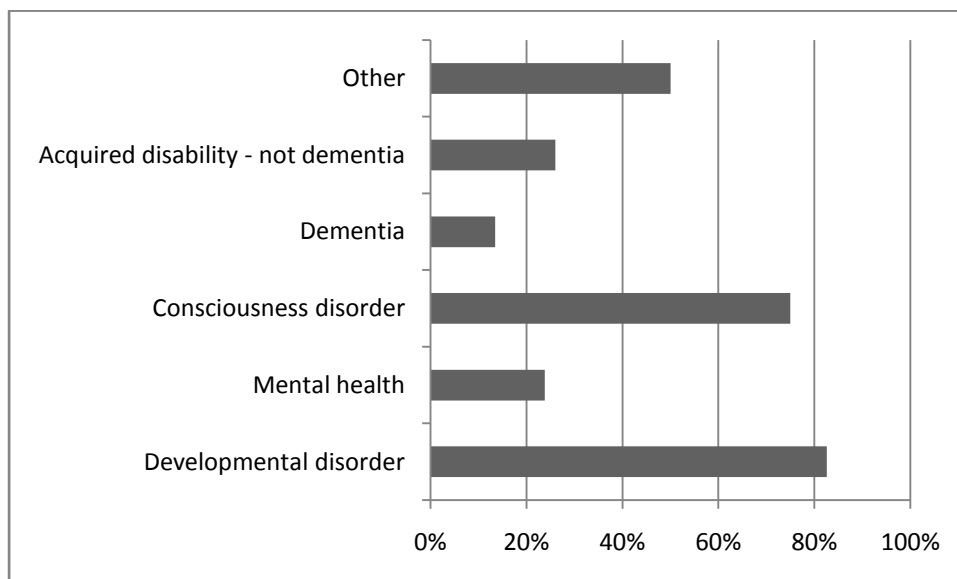
<sup>940</sup> With kind permission of Jordan's publishing.



**Figure 12 Applications for permission received by P's diagnosis**



**Figure 13 Success rate of applications with known outcome by diagnosis of P**



## C2 INFORMATION ABOUT COURT OF PROTECTION VISITORS FROM THE OFFICE OF THE PUBLIC GUARDIAN

Data source: Response to a FOIA request for information from the OPG (FOIA #18). The information from the OPG is as follows:

Visitors are appointed under a Lord Chancellor contract and are contractors rather than civil servants. Section 61 of the Mental Capacity Act 2005 states that:

...a person cannot be a special visitor unless they are a registered medical practitioner or appears to the Lord Chancellor to have other suitable qualifications or training, and appears to the Lord Chancellor to have special knowledge of and experience in cases of impairment of or disturbance in the functioning of the mind or brain.

General visitors need not have a medical qualification. In addition to the above visitors there are 3 permanent general visitors who are civil servants and operate under s58 of the Mental Capacity Act as opposed to Section 61.<sup>941</sup>

**Table 11 Number of Court of Protection Visitors in England, by region, as of October 2012**

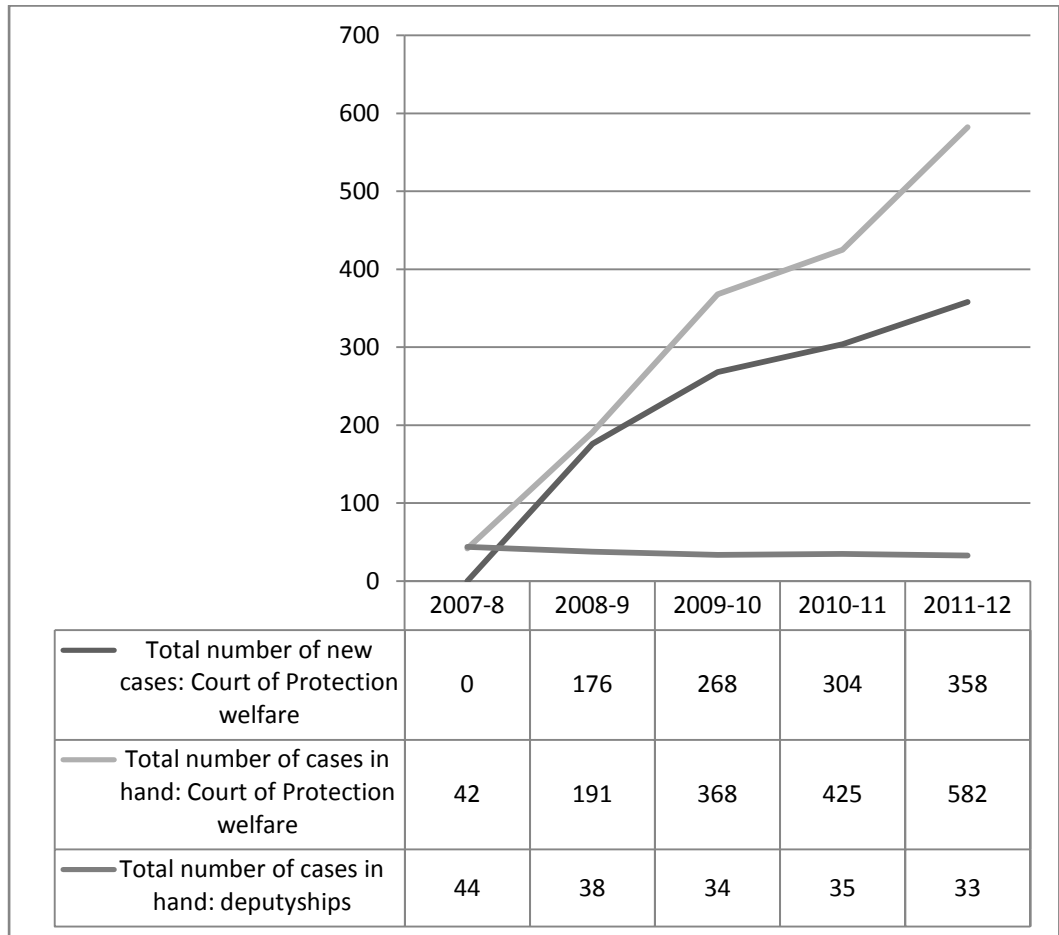
Region	Special Visitor	General Visitor
South West	1	6
South East	2	14
London	3	9
East of England	0	4
West Midlands	1	8
East Midlands	1	5
Yorkshire/Humber	1	2
North West	1	7
North East	0	5
Wales	1	4
<b>TOTAL</b>	<b>11</b>	<b>64</b>

## C3 OFFICE OF THE OFFICIAL SOLICITOR

Data source: Annual reports of the Official Solicitor and the Public Trustee (Office of Court Funds Official Solicitor and Public Trustee, 2008; 2009; 2010; Office of the Official Solicitor and the Public Trustee, 2011; 2012).

<sup>941</sup> More detailed information on the recruitment process for Court of Protection visitors is available in the information supplied by the OPG, see the link to the third party website hosting the request.

**Figure 14 Number of Court of Protection welfare and deputyship cases involving the Official Solicitor**



## C4 PROSECUTIONS UNDER S44 MENTAL CAPACITY ACT 2005

Data source: Freedom of Information Act 2000 (FOIA #3; #4)

**Table 12 The number of prosecutions initiated by the CPS under s44 MCA or s127 MHA**

	2007 -08	2008 -09	2009 -10	2010 -11	2011 -12	2012 - 2013 (to 24 July 2012 )
s44 Mental Capacity Act 2005	9	43	101	191	177	77
s127(1) & s127 (3) Mental Health Act 1983			7	12	6	15
s127(2) & s127(3) Mental Health Act 1983	Not requested		0	1	0	2

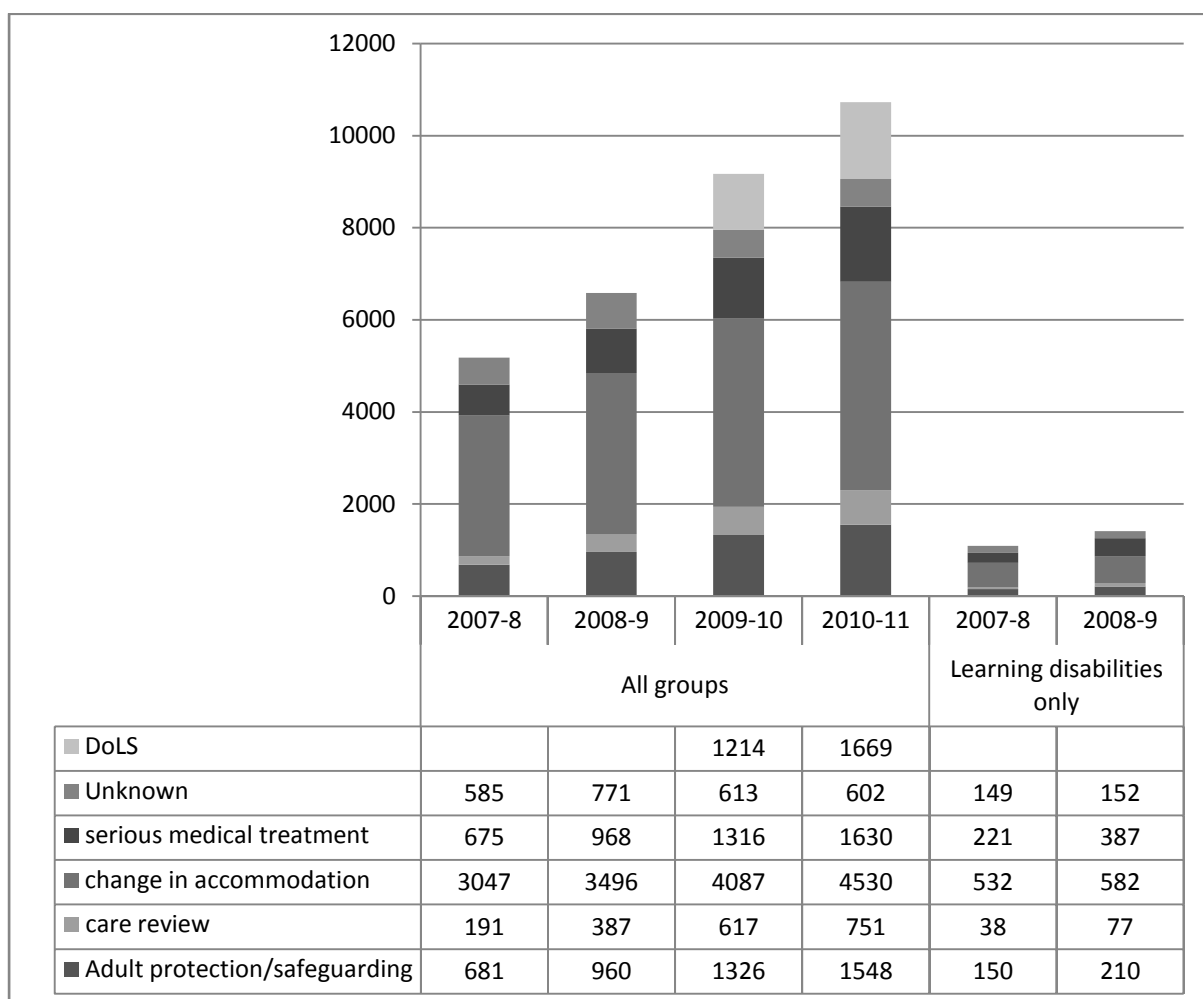
Data refers to the number of prosecutions which reached a hearing in the magistrates courts; outcomes are not recorded.

## C5 INDEPENDENT MENTAL CAPACITY ADVOCACY SERVICE

Data source: Annual reports of the IMCA service (Department of Health, 2008c; 2009c; 2010d; 2011b). Also Freedom of Information Act 2000 request for data on s39D IMCA for the 2009-10 (FOIA #13).

In total there were 5179 IMCA referrals in 2007-8 (32% of impact assessment predictions), there were 6582 in 2008-9, 9173 in 2009-10 and 10730 in 2010-11. For the years 2009-11 these also included figures for DoLS IMCAs, the total number of non-DoLS IMCA referrals for 2009-10 was 7959 and there were 9061 for 2010-11. Referrals to represent adults with learning disabilities make up approximately 20-22% of all IMCA referrals.

**Figure 15 Breakdown of IMCA referrals 2007-11**



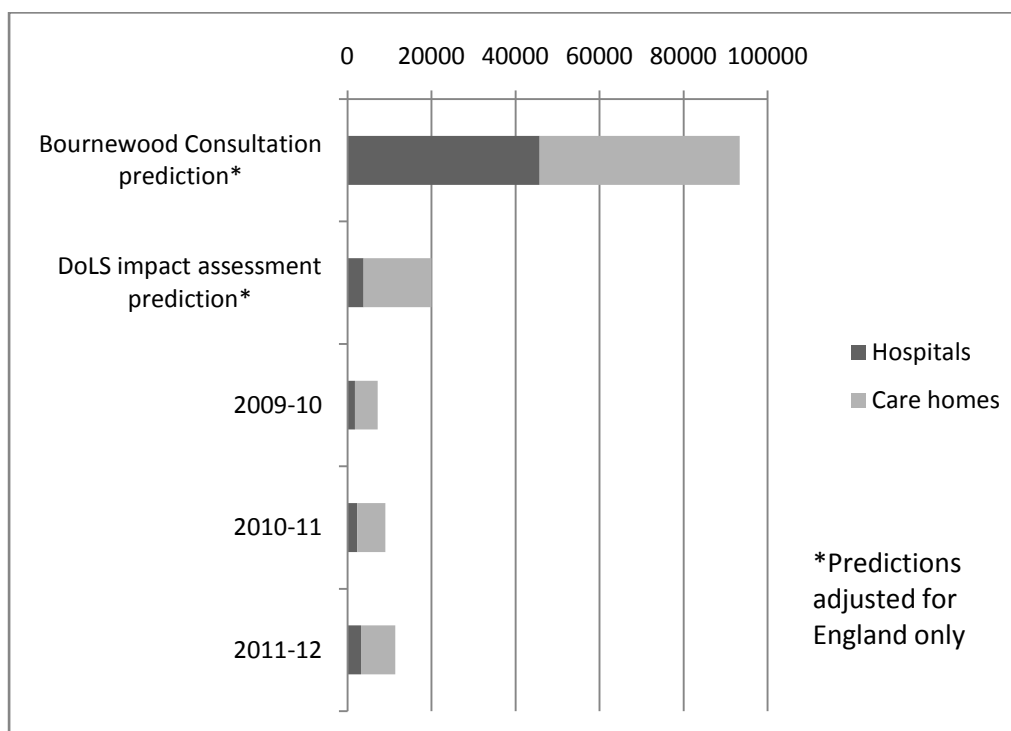
**Table 13 Number of formal complaints and Court of Protection proceedings initiated by IMCAs, 2009-11**

	2009/10	2010/11
Total number of formal complaints	14	13
Number of formal complaints as % of total number of referrals	0.15%	0.12%
Complaints against the local authority	8	9
Complaints against the health authority	6	4
Cases where IMCA referral led to application to Court of Protection	6	4
Number of Court of Protection proceedings initiated by IMCAs as % of total number of referrals	0.07%	0.04%

## C5 APPLICATIONS UNDER THE DEPRIVATION OF LIBERTY SAFEGUARDS

Data source: Consultations, impact assessments and official statistics for the deprivation of liberty safeguards (Department of Health, 2005a; 2007b; NHS Information Centre for Health and Social Care, 2010a; 2011d; 2012f).

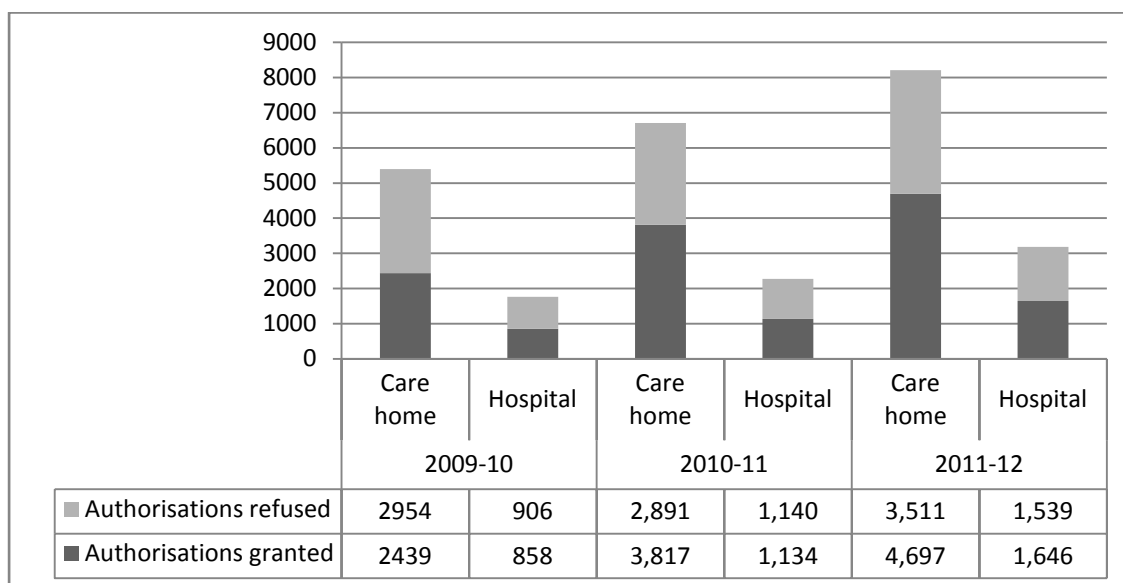
**Figure 16 Number of DoLS applications per year - predicted and actual data (England)**



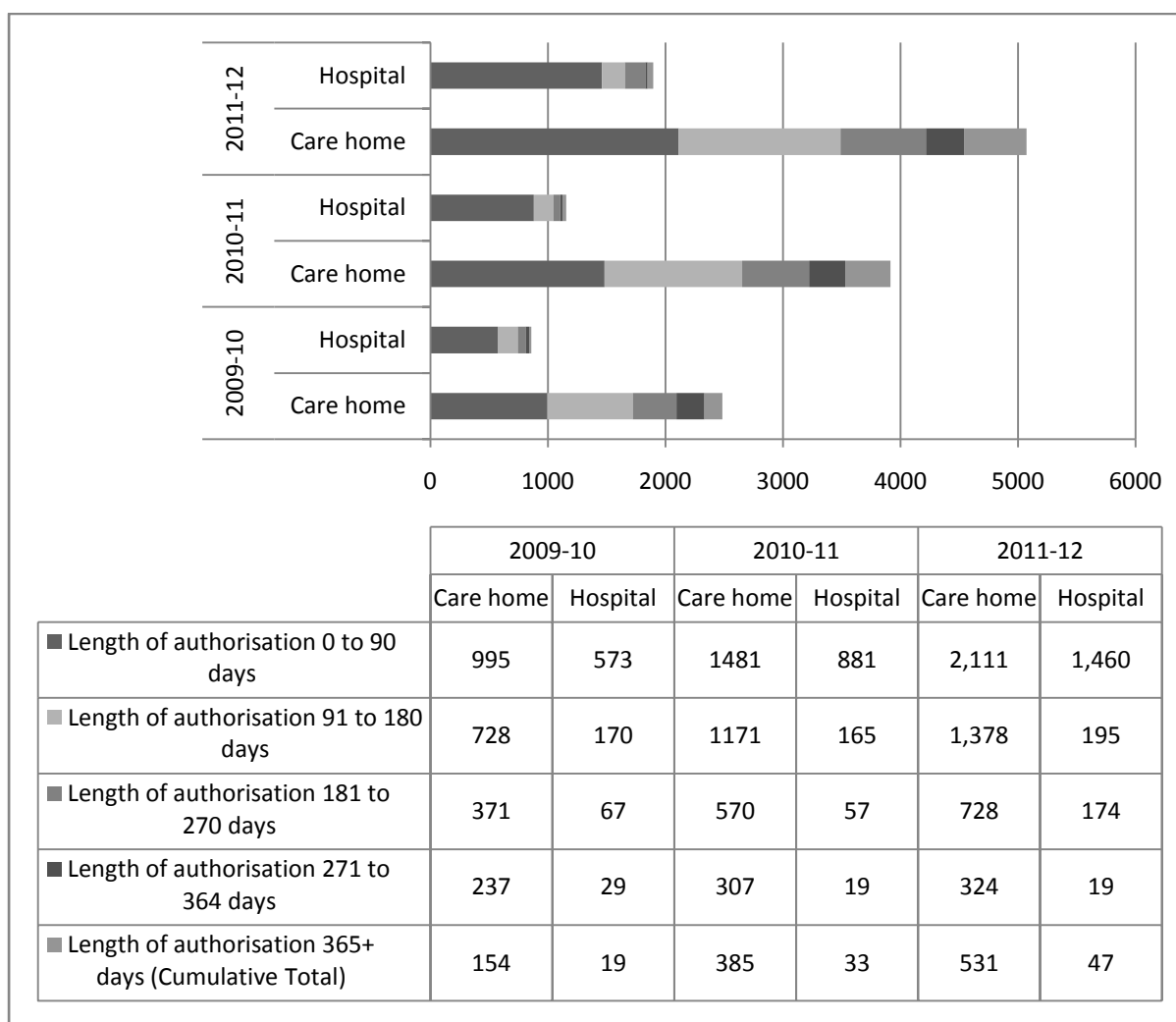
### OFFICIAL STATISTICS ON DOLS ACTIVITY, 2009-2012

Data source: This is a breakdown and graphical depiction of data given in the supporting tables of the official statistics collected by the government on the deprivation of liberty safeguards (NHS Information Centre for Health and Social Care, 2010b; 2011e; 2012f).

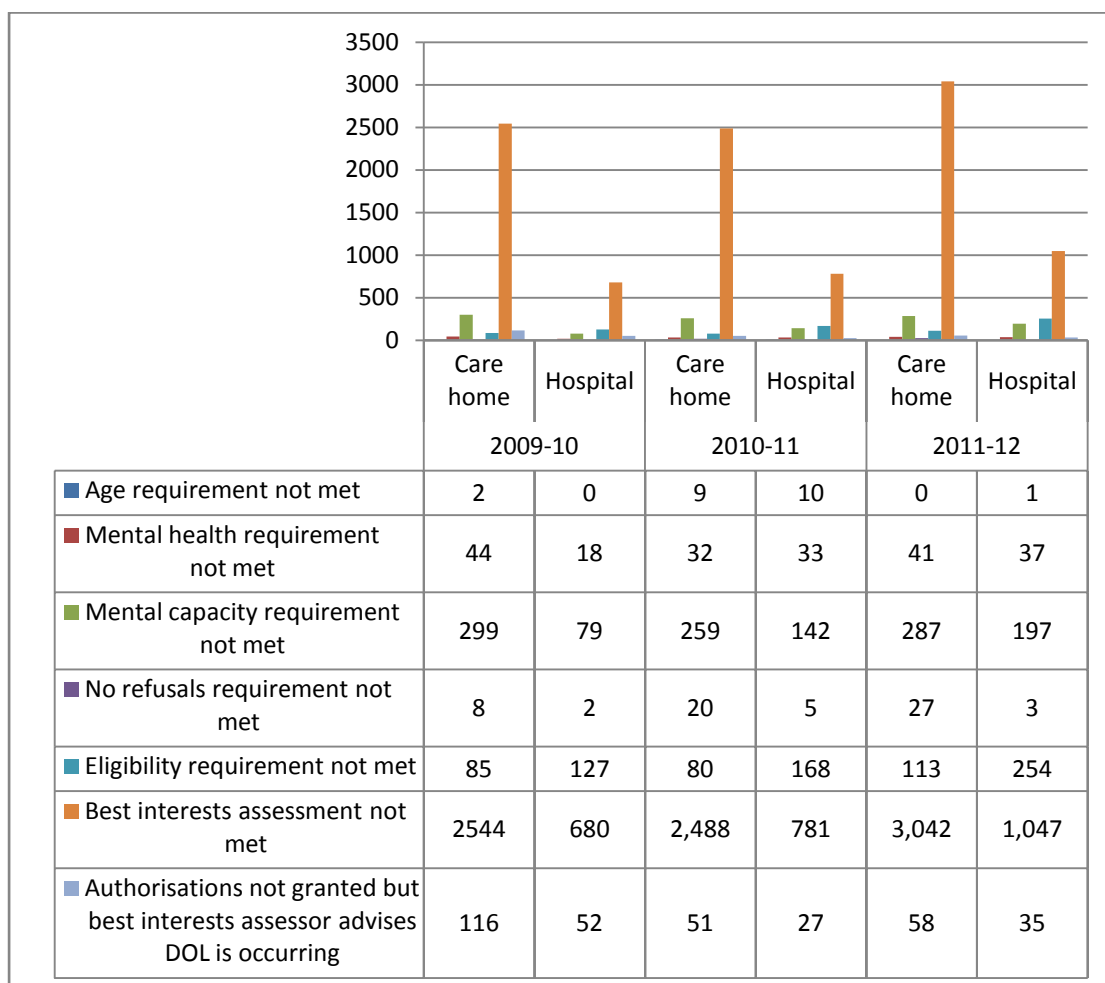
**Figure 17 Number of applications granted and refused for care homes and hospitals, 2009-2012**



**Figure 18 Durations of authorisations granted by care homes and hospitals, 2009-12**



**Figure 19 Qualifying requirements not met for deprivation of liberty applications from care, 2009-12**



**USE OF THE THIRD PARTY REFERRAL MECHANISM FOR CONSIDERATION OF WHETHER CARE AMOUNTS TO A DEPRIVATION OF LIBERTY**

Data source: Local authority responses to the question ‘In how many instances has the deprivation of liberty assessment process been triggered by a third party contacting the supervisory body about a possible unlawful deprivation of liberty?’ at November 2010 (FOIA #29). This was fourteen months into the operation of the DoLS.

**Table 14 Number of times a third party or CQC alerted local authority supervisory bodies to a possible unlawful deprivation of liberty (April 2009 – November 2010)**

	3rd Party Requests to supervisory body	CQC alert supervisory body to possible unlawful deprivation of liberty
Total	165	24
Highest number received by a local authority	25	9



Lowest number received by a local authority	0	0
Median number of requests/alerts for local authorities	0	0
Mean number of requests/alerts for local authorities	1.375	0.2
Number of local authorities responding to this question	120	120
Number of local authorities responding zero requests/alerts	67	112

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APPLICATIONS TO THE COURT OF PROTECTION CONCERNING DEPRIVATION OF LIBERTY

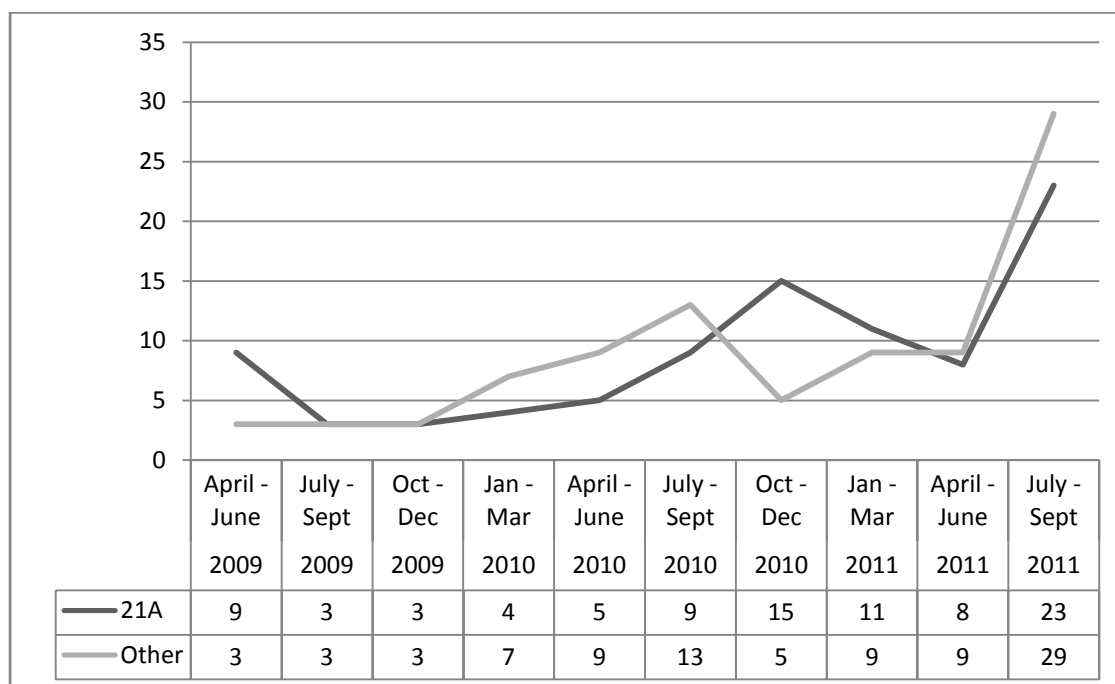
Source: FOIA requests (FOIA #15; #16; #29).

**Table 15 Identity of applicant in DoLS appeals brought between April 2009 and January 2011**

	Section 16 MCA	Section 21A MCA
Advocates /IMCAS	3	2
Local Authority	24	3
Nursing Home	1	1
NHS Body	0	2
Applicant in person	5	8
Solicitor*	23	14
Total	56	30

\*It was not possible to break down data on solicitors for P, R and other parties.

**Figure 20 Number of appeals against detention under the Mental Capacity Act 2005, April 2009-September 2011**



**Table 16 Number of DOLS court cases local authorities have been involved in (FOIA #29)**

0 Court cases	101
1 Court case	12
2 Court cases	7
7 Court cases	1
<b>Total number of court cases</b>	<b>33</b>
<b>Number of local authorities responding to this question</b>	<b>121</b>

## C6 PUBLIC FUNDING FOR COURT OF PROTECTION CASES

Details of arrangements for public funding for legal advice and representation in the Court of Protection taken from guidance provided by the Legal Services Commission (LSC 2011c; b; a; 2012a; b). As of 1 September 2012<sup>942</sup> many elements of the controversial Legal Aid, Sentencing and Punishment of Offenders Act 2012 (LASPO) came into force, which may have a significant effect on public funding for many areas that affect people who 'lack capacity' (Official Solicitor, 2011). Nevertheless, the core requirements for funding for Court of Protection litigation have remained intact, although financial eligibility requirements are more stringent. This information, whilst now out of date, is provided to give an indication of the types of access to justice barriers connected

<sup>942</sup> The Legal Aid, Sentencing and Punishment of Offenders Act 2012 (Commencement No. 1) Order 2012 SI 2012/1956

with funding for litigation that existed under the regime before LASPO. If anything, the situation will have worsened since LASPO came into force.

## C6.1 PUBLIC FUNDING FOR S15 AND S16 MCA MATTERS

Subject to other requirements, funding for legal help is available for making Lasting Powers of Attorney and advance decisions where the client is aged over 70 or is a disabled person within the meaning of s1 Disability Discrimination Act 1995 (Legal Services Commission, 2011b: 383).

Subject to other requirements, funding for legal help, help at court and legal representation in the Court of Protection is available for litigation concerning the following matters:

- a person's right to life,
- a person's liberty or physical safety,
- a person's medical treatment (within the meaning of the Mental Health Act 1983),
- a person's capacity to marry, to enter into a civil partnership or to enter into sexual relations, or
- a person's right to family life.<sup>943</sup>

The LSC (2011b: 28.3 [6]) comment:

Many welfare cases concern accommodation issues which will not as such fall within the scope of the authorisation. However accommodation cases will be within scope where they concern P's family life. This is likely to be the case where either the issue is whether or not P should remain with his or her family or where a change of accommodation would have a serious impact on contact between P and his or her family. Cost Benefit criteria may also be an important consideration in such applications.

The LSC (2011b: 383-4) must be satisfied that it is necessary for a person to be represented at an oral hearing, or other parties such as a person's immediate family. In deciding whether or not cases fall within the category of serious health and welfare matters, the LSC will take into account case law, including that which was previously heard under the inherent jurisdiction of the High Court. The LSC note that guidance issued by the Official Solicitor (2001) says that 'any serious treatment decision where there is a disagreement between those involved and those close to P, where the treatment proposed may involve the use of force to restrain P or otherwise may be resisted by P or where there are doubts and difficulties over the assessment of either the

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<sup>943</sup> This is preserved by Part 3 Schedule 1 LASPO

person's capacity or best interests should be referred to the court.'<sup>944</sup> The LSC comments that 'Many, but not all, cases within that guidance will also come within the terms of the authorisation'.

In considering whether or not to fund legal representation for parties other than 'P' the LSC would consider (amongst other factors) their interest in the matter and the case they wish to put forward. In general, the LSC:

...will only grant Legal Representation if the applicant wishes to put forward a new and significant argument which would not otherwise be advanced. As a rule there should not be more parties separately represented before the Court than there are either cases to put or desired outcomes.<sup>945</sup>

Cases must also satisfy merits criteria to qualify for public funding:

Cases before the Court of Protection are likely to be considered under the general Funding Code. The most important criteria will often be prospects of success. Many (but not all) of the cases which come within para.6 of the authorisation also fall within the test of 'Overwhelming Importance to the Client' as defined in s.2.4 of the Funding Code. For cases of overwhelming importance to the client the requirement is to have at least borderline prospects or achieving the outcome desired by the applicant. For this purpose in relation to applications on behalf of the family of 'P' the issues will be treated as of overwhelming importance to the applicant if they are of overwhelming importance to "P's".

Applicants for public funding are also subject to a financial eligibility test (Legal Services Commission, 2012a; b). At the time of writing, an applicant's gross income must not exceed £2657<sup>946</sup> and their disposable income must not exceed £733 per month after allowances are made for dependants and employment expenses, and other allowances including: tax; national insurance; maintenance paid; housing costs; child-care incurred because of work; and criminal legal aid contributions. People in receipt of certain passporting benefits<sup>947</sup> would satisfy the income test.

There is also a test of disposable capital. If a person's disposable capital exceeds £8000 they will not qualify for legal aid. The value of a client's main or only dwelling which he is living in would be taken into account unless the property itself is the subject matter of the dispute. The property would be valued at the amount it could be sold for on the open market, and the amount of any mortgage or charges registered against the property should be deducted up to a maximum deduction of £100,000. In

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<sup>944</sup> This is the LSC's paraphrasing of the OS's guidance, not the phrasing used by the OS himself.  
<sup>945</sup> p385

<sup>946</sup> A higher gross income cap applies to families with more than four dependent children.

<sup>947</sup> Income Support, Income Based Job Seekers' Allowance, Income Based Employment and Support Allowance or Guarantee Credit.

addition, the first £100,000 of the value of a client's interest after making deductions for any mortgages must be disregarded. The LSC (2012b) give some worked examples:

The applicant has a home worth £215 000 and the mortgage is £200 000:

Value of home: £215 000

Deduct mortgage up to maximum allowable: £100 000

Deduct exemption allowance: £100 000

Amount to be taken into account in assessing financial eligibility: £15 000

In this example, the client is ineligible.

More complex rules apply for owners of multiple properties. The Official Solicitor has noted that the capital disregard rules can be extremely problematic for his client's, who may not be in a position to release equity from the value of their property or to sell the property and move (Pitblado, 2012). The LSC (2011b: 386) comment:

Cases before the Court of Protection are generally subject to the usual financial eligibility rules for CLS funding. Neither the Lord Chancellor nor the Commission have any powers to waive eligibility levels or contributions in such cases.

## C6.2 PUBLIC FUNDING FOR APPEALS AGAINST DETENTION UNDER S21A MCA

Public funding for legal advice and legal representation of detainees and the 'relevant person's representative' is not subject to any financial eligibility test to bring an appeal against a deprivation of liberty authorised under Schedule A1 MCA if the appeal is brought under s21A MCA.<sup>948</sup> However, this 'gold plated' legal aid is only available for people detained using Schedule A1 – the DoLS. People deprived of their liberty outside of the DoLS, for example subject to an order of the Court of Protection under s16 MCA, would still be subject to both the means and merits tests described above. Third parties wishing to mount a challenge to a detention under the DoLS who are not P's appointed representative, would also not qualify for this 'gold plated' legal aid and would be subject to the means and merits tests described above.

A related difficulty occurs where a dispute over deprivation of liberty – even that authorised under the DoLS – arrives in court by way of a public authority seeking a declaration or order under s15 or s16 MCA. In such cases, because the hearing would not be under s21A MCA, and although it may consider identical issues, a person would not be entitled to 'gold plated' legal aid as they would if the case were brought by themselves or their representative under s21A MCA. Sometimes it can be difficult to

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<sup>948</sup> r3(ea)The Community Legal Service (Financial) Regulations 2000, as amended by r5 Community Legal Service (Financial) (Amendment) Regulations 2009.

distinguish which welfare issues fall to be considered under s16 MCA and s21A MCA. In some cases, although case has arrived in court under s21A MCA a judge might terminate the authorisation under Schedule A1 and replace it with an authorisation from the court under s16 MCA. In such circumstances, it can be difficult to persuade the LSC that anything beyond the first hearing constitutes a s21A MCA appeal for the purposes of securing 'gold plated' legal aid (Ruck Keene et al., 2012d). Recently Charles J directed that such proceedings should continue to be considered proceedings under s21A notwithstanding any s15 or s16 MCA declarations or orders.<sup>949</sup>

Even if bringing an appeal against their detention is of overwhelming importance to a person, it might not satisfy the LSC's requirements of at least 'borderline prospects of success'. This may cast doubt on what funding might be in place for cases like *A v A Local Authority & Ors*<sup>950</sup> where the court emphasised the importance of not simply 'rubber stamping' deprivation of liberty authorisations in situations where all professionals and family members were in agreement as to a person's best interests yet they themselves continue to object (Ruck Keene and Butler-Cole, 2011).

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<sup>949</sup> *Re HA* [2012] EWHC 1068 (COP)

<sup>950</sup> [2011] EWHC 727 (COP)

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<sup>951</sup> Where the case is referred to in the body of the text, it refers to the asterisked hearing rather than other hearings, unless otherwise specified.



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