

Consultation Response

The
Disabilities Trust



www.thedtgroup.org

Mental Capacity and Deprivation of Liberty

02.11.2015

The Disabilities Trust is a national charity, providing care, rehabilitation and support for people with profound physical impairments, acquired brain injury and learning disabilities as well as children and adults with autism. The Trust's income largely derives from fees charged to the NHS and local authorities to provide these specialist services. The organisation supports approximately 1,000 people each year in residential settings, in independent hospitals, accommodation based support and within individuals' own homes; we employ over 2000 staff and have an annual turnover of c£55m.

The Trust has elected to respond to those consultation questions which raised significant issues for both our service users and people with complex disabilities more widely. Whilst we broadly welcome the proposals outlined by the Law Commission, we are concerned that provision has not been made for individuals who are in a rehabilitation setting and whose condition and capacity to consent fluctuates or is in a period of rapid change, such as those with an acquired brain injury. We would welcome further clarification of how protective care in private homes and community settings will work though we believe this is a positive step forward for the people we support. The Disabilities Trust supports people with a wide variety of disabilities and we would consider being a pilot for any new arrangements.

Provisional proposal 2-1: the Deprivation of Liberty Safeguards should be replaced by a new system called "protective care".

We do not feel that "Deprivation of Liberty" is an appropriate name, and we welcome the opportunity to rename something that has become increasingly contentious. The families we work with appreciate that measures are enacted only in the best interests of the service user and the term as it stands can cause unnecessary distress. However, we do not feel that the new proposed terms of "protective care" and "restrictive care and treatment" fully express the intentions behind them. Many of our service users who lack insight would feel insulted by the notion of being held in "protective care" when they do not recognise their own deficiencies. Equally, the notion of "restrictive care and treatment" still emphasises the deprivation of liberty rather than the prevention of harm and preservation of life. Our suggestion would be for the language used to be reassuring rather than concerning. Restrictions are very often protective, so the term "limitations to activity" or "limitation of activity" might be preferable to referring to restrictions in activity.

Provisional proposal 2-2: the introduction of protective care should be accompanied by a code of practice, and the UK and Welsh Government should also review the existing *Mental Capacity Act Code of Practice*.

We agree with the introduction of the code of practice, but there needs to be suitable dissemination and support in training to raise awareness in professionals regarding this code.

Question 3-1: have we identified the correct principles to underpin protective care, namely that the scheme should deliver improved outcomes, and be based in the Mental Capacity Act, non-elaborate, compliant with the European Convention on Human Rights, supportive of the UN Disability Convention, and tailored according to setting?

Generally we agree that the correct principles have been identified, though we would appreciate further clarification on several matters. On what criteria will outcomes be measured: a reduction in legal claims where people have challenged their DoLS, a reduction in waiting times for decisions, increased satisfaction for service users, their families and staff, or on another, alternate measure?

Provisional proposal 4-1: the scope of protective care should include hospital, care home, supported living, shared lives and domestic accommodation.

Overall we welcome the proposals to extend the scheme, but believe any new measures must be proportionate and must include provision for fluctuating capacity and guidance on restrictions that would fall under the new scheme and that which would be considered 'duty of care'. People getting support in domestic settings might not need this type of heavy-handed approach, and should be free to come and go, with or against the advice of care staff, with an understanding that the individual risks will sometimes be high.

It seems that all people in any type of care will have to be assessed to look at their capacity and best interests. This is hardly workable, and the same backlogs are going to occur in administration of the scheme. While the principle of the new scheme are good, the operationalisation of the three tiered scheme may be as complicated and slow as the DoLS, due to the complex nature of service users in social care. The Trust supports a large number of people who would fall under the new scheme but are currently not eligible for DoLS. Whilst our staff have received training on DoLS and our organisation as a whole is fully prepared for this expansion, we do not believe that the Local Authority support is there given the current delay and backlog in processing the vastly increased number of DoLS application post-Cheshire West. This issue would need to be addressed to ensure providers' applications under the new scheme are processed in a timely manner.

Question 4-2: is the definition of supported living provided under the Care Act appropriate for our scheme?

The Trust provides support under a variety of models including recognised Supported Living schemes, accommodation based services and the persons own home (which they own or rent directly). We would regard accommodation based support as equivalent to own home support.

Provisional proposal 6-1: supportive care should apply where a person is living in care home, supported living or shared lives accommodation, or if a move into such accommodation is being considered.

Provisional proposal 6-2: supportive care should cover people who may lack capacity as a result of an impairment of, or a disturbance in the functioning of, the mind or brain, in relation to the question whether or not they should be accommodated in particular care home, supported living or shared lives accommodation for the purpose of being given particular care or treatment.

In order to fully respond we would require further clarification on the term "living in". Does this refer only to those people resident for permanent or long-term care, or is it also intended to cover assessment periods or respite care? At present, the distinction between 'hospital' and 'care home' is

too rigid and does not make acknowledgement of the expertise of short- to medium-term assessment facilities providing post-hospital care, but not intended as a permanent ordinary residence. The “supportive care” measures should also be extended to cover people in own home support.

We have various examples of cases that ‘fell through the cracks’ of the previous system. For example, people needing transferred from residential care settings to mental health hospital settings, where the mental health team do not consider the person is sectionable under the MCA, and the DoLS team do not feel the case is suitable for a DoLS. We have people with complex histories and brain injuries or brain damage who hire solicitors to remove their DoLS, only to find it difficult to support that person with one-to-one 24-hour support when they start self injuring (significantly). They do not want that intrusion, and so are left with less frequent observations. There are people who have fluctuating capacity (prolonged seizure disorders), who need extra support when mentally affected, which does not occur all the time or in a predictable pattern. The extension of the current scheme should take into consideration those with changing needs who will move between services, as these cases are likely to become increasingly common. Statutory services should be preparing for people to use their personalised budgets in a changing and flexible way as needs develop and change across the years.

Provisional proposal 6-3: a local authority should be required to undertake or arrange an assessment, or ensure that an appropriate assessment has taken place, where it appears that a person may be eligible for supportive care in care home, supported living or shared lives accommodation.

Not all of our service users are funded by their Local Authority; many are funded by the NHS, either through NHS England, CCGs or Continuing Healthcare (CHC) and it is not uncommon for our service users to transition from one funder to another. This is of particular relevance in our brain injury services where someone may transition over a period of years from post-acute rehabilitation in a hospital setting, to a rehabilitation and assessment facility, to community based care to living in their own home, whilst at all stages lacking (or fluctuating in) capacity to the extent that they remain under the DoLS remit. Therefore the question of a Local Authority assessment is not always relevant.

Our experience of both Local Authority and NHS funding is that parameters for care vary significantly and interpretation of DoLS can have extensive impact on our delivery of care. As the Trust operates highly specialised facilities across the country our service users are often from out-of-area and the lack of consistency in funding and assessment places immense pressure on our staff. Standardisation may be something to be considered as part of this review of DoLS.

Provisional proposal 6-4: the local authority must ensure that the assessor has the skills, knowledge and competence to carry out the assessment and is appropriately trained. The assessor must consult a person with expertise in relation to the condition or circumstances of the individual, where the assessor considers that the needs of the individual require them to do so.

It has been our experience that the skills, knowledge and competence of the assessors conducting the assessment varies enormously. Often the assessor has never met the individual before and does not know the background to the case, leading to a rushed assessment and a ‘rubber stamp’ exercise. The assessment is not always rigorous or designed for an individual whose condition may fluctuate, and may exhibit appropriate behaviour during an assessment but be generally unsafe.

The expertise of the professionals that have been working closely with the individual are often dismissed or disregarded in favour of the Local Authority assessor’s own interpretation leading to

protracted legal situations to ensure DoLS are in place which can be extremely stressful for the service user, their family and our staff. We have had several instances where our clinical staff including neuropsychologists have considered a person to lack capacity following an intensive assessment process, only for local authority assessments to conclude they have capacity based on a brief meeting. It would indicate that there is not a universal test and that the standards used vary, possibly on the basis of profession and experience. The importance of considering information provided by care and medical staff within the setting and ensuring all assessments are evidence based should be noted by the Law Commission in their report.

Question 6-10: should local authorities and the NHS in England ever set personal budgets for disabled people living at home by reference to the cost of meeting the person's needs in residential care?

No - provision should be needs-led as indicated in the Care Act.

Question 6-11: should there be a duty on local authorities and the NHS, when arranging care home, supported living or shared lives accommodation for a person who lacks capacity to decide where to live:

- (1) to secure the most appropriate living arrangement for that person, which as far as possible reflects the person's wishes and feelings; and**
- (2) to seek the agreement of any donee of a Lasting Power of Attorney or deputy, or a declaration from the Court of Protection.**

(1) Yes – providing it meets their needs. If someone needs a specialist provider such as for acquired brain injury then the ability to meet the presenting care needs should take precedence.

(2) This raises legal questions that we would need clarified in order to fully respond: Does someone who holds a Health and Welfare Order have the right to make a decision contrary to the advice of others such as professionals involved? We have some service users with Court Orders and this trumps all other decision-making processes, although in practice many day-to-day decisions are delegated to the care provider and medical professionals.

Provisional proposal 6-13: all registered care providers should be required to refer an individual for an assessment under the relevant protective care scheme if that person appears to meet the relevant criteria.

If the criteria for referral are clear this is not problematic, but if there is a lack of clarity in the process then it is unfair to place the requirement so explicitly on the registered care provider. In practice we have referred a number of people following Cheshire West with very little response. Such a requirement needs to be clear about responsibilities of all parties e.g. the care provider refers and the Local Authority assessors. What happens if, as in our frequent experience, the Local Authority does not respond?

Provisional Proposal 7-1: the restrictive care and treatment scheme should apply to people who lack decision-making capacity as a result of an impairment of, or a disturbance in the functioning of, the mind or brain.

We strongly agree.

Provisional Proposal 7-3 and Question 7-4:

It is important to clarify and separate out the intentions within these two proposals. Many of our service users have profound and multiple complex physical needs such as needed help to be hoisted into a wheelchair; this does not in itself mean that they are being restricted in their liberty. Prior to Cheshire West, applications for DoLS were declined with the explanation that given the presentation of the individuals needs they are not being deprived of liberty if, for example, they require straps to safety support them in a seated position in a chair. In the atmosphere of uncertainty post-Cheshire West it is again unclear as to what constitutes a deprivation of liberty and what would be considered a duty of care, and consequently DoLS are applied for with increased frequency in order to ensure providers stay within the law.

The focus of the replacement to the DoLS should be on enabling and supporting those with disabilities. It may be more straightforward to divide this into two concepts: care and treatment which is welcomed and accepted, and care and treatment that is resisted or unwanted although some level of intervention is required. Both would require oversight to check that rights are respected and abuses identified, but it would be recognised that there is a difference between the two situations.

Question 7-5: are there any specific forms of care and treatment that should automatically mean that the person is eligible for the restrictive care and treatment safeguards?

Instances in which an individual is not only expressing a wish to leave, but is actively seeking to leave in a physical way which is likely to cause harm to themselves or others, and where physical restraints or medication must be used to prevent this. On occasions where an individual has expressed a desire to leave, is aware of possible routes to leave by, but has not initiated any action towards leaving, the automatic safeguards would not be appropriate. We would appreciate clarification around what would be considered restrictive in a similar scenario where the individual in question lacks initiation due to the nature of their brain injury.

Provisional proposal 7-6: the local authority should be required to ensure that an assessment for restrictive care and treatment takes place, and confirm that the restrictive care and treatment is in the person's best interests.

See response to 6.3. We have found that where the NHS is the funder for an individual the CCG is often reluctant to engage with DoLS issues as they consider it to be a Local Authority issue. A clearer responsibility structure would be appreciated in these instances.

Question 7-7: should the restrictive care and treatment assessment require a best interests assessment to determine whether receiving the proposed care or treatment is in a person's best interests, before deciding whether it is necessary to authorise restrictive care and treatment?

In broad terms there is merit in assessing if the proposed care provider can manage the person and has specialist knowledge to manage the condition and/or behaviour. A specialist may be able to deal with behaviour in a less restrictive way than a non-specialist provider. However, when people receive a service from the Trust it is because it has been identified that they require a specialist service, so this has in effect already been done.

Within our services it is important to be able to authorise something quickly to protect the individual and the staff attempting to keep them safe so waiting on a best interests assessment is not necessarily helpful; the situation for longer term placements may be different but in acquired brain injury post-acute rehabilitation setting there is a rapidly evolving pattern of agitation and recovery. DoLS are now applied for as a matter of course at the point of admission to many of our services,

undermining the principles behind their introduction. This is as a direct result of the heavy-handed judgement laid out in Cheshire West; consequently, our staff prefer to apply pre-emptively for DoLS and enact them when necessary rather than wait for an emergency situation to arise given the immense backlog in Local Authority processing time.

Question 7-8: should a person be eligible for the restrictive care and treatment scheme if restrictive care and treatment is necessary in their best interests – taking into account not just the prevention of harm to the person but also the risks to others?

Yes, and we strongly support both the prevention of harm to self and the addition of “risks to others”.

Provisional proposal 7-11: restrictive care and treatment assessments should be referred to an “Approved Mental Capacity Professional” (currently, the best interests assessor) who would be required to arrange for the assessment to be undertaken by a person already involved in the person’s care (e.g. the person’s social worker or nurse) and quality assure the outcome of that assessment or oversee or facilitate the assessment; or undertake the assessment themselves.

See response to 6-4. We would want assurances that quality of assessment would be consistent and accurate and that assessors and the AMCP have the appropriate knowledge and training.

Provisional proposal 7-15: restrictive care and treatment should enable Approved Mental Capacity Professionals (currently, Best Interests Assessors) to use equivalent assessments where this is necessary.

Yes – this should also include existing assessment evidence gathered by the specialist staff team who have been working with the individual and will have a greater understanding of their needs. This is particularly relevant in complex cases such as acquired brain injury.

Provisional proposal 7-17: the Health and Care Professions Council and Care Council for Wales should be required to set the standards for, and approve, the education, training and experience of “Approved Mental Capacity Professionals” (currently, Best Interests Assessors).

Whilst we support this proposal, in our experience BIA can vary widely in terms of their expertise which can have a negative outcome for our service users. If this role is to be enhanced and given greater prominence it is crucial that they are required to have experience which is relevant and knowledge which is up-to-date, particularly when dealing with individuals with complex needs and conditions.

Provisional proposal 7-18: the ability to practise as an “Approved Mental Capacity Professional” (currently, the Best Interests Assessor) or Approved Mental Health Professional should be indicated on the relevant register for the health or social care professional.

We support this interesting proposal.

Question 7-19: should there be additional oversight of the role of the “Approved Mental Capacity Professional” (currently, the Best Interests Assessor) and a right to request an alternative assessment?

It is important to safeguard the right to request an alternative assessment, and/or appeal the result, particularly if the initial assessment is flawed.

Provisional proposal 7-20: the “Approved Mental Capacity Professional” (currently, the Best Interests Assessor) should be responsible for setting conditions and making recommendations in respect of the person’s care and treatment.

We believe that the role should be limited to assessing capacity rather than specifically setting conditions. As outlined in response to proposals 6-3, issues arise when an assessor without a thorough understanding of an individual’s capabilities or the decision-making behind care and treatment processes imposes their conditions. We would welcome a more questioning and interested approach from AMCPs in order to gain a better understanding of the individual’s need, but they may not be best placed to advise.

Provisional proposal 7-21: the “Approved Mental Capacity Professional” (currently, the Best Interests Assessor) should be given responsibility for monitoring compliance with conditions. This could be delegated to health and social care professionals who are allocated to the case, and advocates and the appropriate person would be required to report any concerns about noncompliance with conditions.

We agree that if any conditions are set they should be monitored in order to ensure the best outcomes for the service user. However if they are inappropriately set and cannot realistically be complied with then what is the AMCP going to do next? What additional powers will be granted to the AMCP to ensure compliance and what will the consequences be for care providers and/or Local Authority or other funders who fail to comply?

Question 7-22: should the new scheme allow for conditions or recommendations to be made that are more restrictive of liberty than the application is asking for?

We support this in principle although feel it is unlikely to occur in practice.

Question 7-23: should there be specific sanctions for a failure to comply with a condition, and if so, what should they be?

See response to 7-21. What input would providers have in determining conditions and what right would they have to appeal against unreasonable conditions? Which regulatory framework bodies would be used to judge compliance with conditions?

Provisional proposal 7-24: an “Approved Mental Capacity Professional” (currently, the Best Interests Assessor) should be allocated to every person subject to the restrictive care and treatment scheme. This should not be the same professional who authorised the restrictive care and treatment.

This seems like an unnecessary measure. How would it be ensured that both AMCP have the required level of experience of complex conditions? What provisions would be in place for instances where the two AMCPs disagree on the appropriate course of care and treatment? How would this link with the roles of RPR and advocate? How will Local Authorities ensure availability of AMCPs and make this role attractive? How will Local Authorities fund these extra processes and ensure they occur in a timely fashion given the current delays? Overall we cannot support this proposal and believe it is ‘overkill’.

Provisional proposal 7-25: the “Approved Mental Capacity Professional” (currently, the Best Interests Assessor) should be required to keep under review generally the person’s care and treatment, and given discretion to discharge the person from the restrictive care and treatment scheme.

It would be better to ensure that appropriate lengths of authorisation are set as part of the initial conditions, and that provisions are included for the provider to request an earlier review if the situation changes.

Provisional proposal 7-26: the “Approved Mental Capacity Professional” (currently, the Best Interests Assessor) should be able to review and vary conditions without necessarily holding a full reassessment of best interests.

This seems counter to the principle of putting the needs of the individual first in all assessments of care and treatment. It is hard to imagine a situation where it is necessary to alter conditions without considering best interests. This is particularly important for people with complex and fluctuating needs.

Provisional proposal 7-27: the local authority should be given general discretion to discharge the person from the restrictive care and treatment scheme. Local authorities could consider discharge themselves, or arrange for their power to be exercised by a panel or other person.

We have significant concerns about this proposal – it requires further clarification and seems to contradict enhancing the role of AMCP. There is the risk that it could be open to misuse by Local Authorities who no longer wish to fund people held under restrictive care. Without a transparent review and discharge procedure endorsed by and participated in by all interested parties the worthy principles behind the new scheme risk being seriously undermined.

Provisional proposal 7-28: the “Approved Mental Capacity Professional” (currently, the Best Interests Assessor) and local authority must review the care and treatment following a reasonable request by the person, a family member or carer, or an advocate or appropriate person.

We are broadly supportive of this proposal but clarification on what would constitute a “reasonable request” would be appreciated. Many of our service users, particularly those with acquired brain injury, do not recognise that they have substantial needs requiring ongoing support. What weight would be given to requests from individuals who lack capacity and/or insight? What timescales would the AMCP and Local Authority have to follow?

Provisional proposal 7-31: the Approved Mental Capacity Professional (currently the Best Interests Assessor) should ensure that before a deprivation of liberty is authorised, objective medical evidence be provided by a doctor or psychologist who is independent of the detaining institution. If appropriate evidence already exists, a fresh assessment should not be required.

Further clarification would be appreciated on what would be considered “objective medical evidence”. In instances of brain injury, would a brain scan be considered appropriate, or would the opinion of an independent medical professional still be required? If scans were appropriate, would there be time limitations imposed on how long these would be considered valid? If additional evidence were required, who would fund this assessment requirement and what delays might there be in obtaining evidence, particularly if this needs to be from an independent source? This proposal seems to be

further complicating medical procedures, and adding intrusive visits and assessments to service users and their families at a time that is likely to already be stressful. The proposal also seems unworkable in emergency situations or rehabilitation settings where conditions fluctuate rapidly.

Question 7-34: should doctors be eligible to act as Approved Mental Capacity Assessors (currently Best Interests Assessors)?

We support this in principle although feel it is unlikely to occur in practice. Medical practitioners are unlikely to have the available time to dedicate to the role. Additionally, their breadth of knowledge and experience will naturally be focused on immediate medical needs rather than longer-term management of holistic care and treatment.

Provisional proposal 7-35: an Approved Mental Capacity Professional (currently Best Interests Assessor) should be able to authorise restrictive care and treatment in urgent cases for up to 7 days, and to extend this period once for a further 7 days, pending a full assessment.

We fully support this measure. As noted in response to other proposals, many of our services provide post-acute rehabilitation where service users naturally have very different requirements to those in a long-term residential care facility. The ability to enact restrictive care procedures in an emergency would be highly valued.

Provisional proposal 7-36: the restrictive care and treatment scheme should include powers to authorise transportation, leave, suspension and transfers. It should also enable care and treatment to be authorised in multiple settings.

We fully support this measure. As we operate a number of different services across the country for varying levels of need, it is not uncommon for service users to move between our facilities. At present we must apply for new DoLS even though the service user is remaining with the same care provider who has a thorough understanding of their needs, just in a different setting. The current complexities also mean applying for DoLS when service users require routine hospital treatment not associated with their condition. Due to the overlap between the DoLS and the Mental Health Act, particularly concerning capacity, we have sadly had a number of instances where an individual has had to be sectioned in order to transfer between settings, or else they would have been receiving inappropriate treatment and we would have failed in our duty of care. This proposal should also consider fully how the new scheme will interact with the Mental Health Act in order to prevent distressing situations like this from occurring.

Provisional proposal 8-1: a separate scheme should be established for hospitals and palliative care settings.

Yes – along with the recognition of rehabilitation services as a staging-post that may be more aligned legislatively with hospitals than other care settings in that they are part of a progressive pathway rather than a permanent place of residence.

Provisional proposal 8-2: a person may be deprived of liberty for up to 28 days in a hospital setting based on the report of a registered medical practitioner. A responsible clinician must be appointed and a care plan produced. Further authorisations for a deprivation of liberty would require the agreement of an Approved Mental Capacity Professional (currently a Best Interests Assessor).

We support the introduction of the 28 day period within a hospital setting. We would welcome a similar provision for rehabilitation settings, though we recognise consideration would need to be given to the appropriate medical professional for initial authorisation. Many care homes use a local GP.

Provisional proposal 9-1: an independent advocate or an appropriate person must be appointed for any individual subject to protective care. The individual must consent to such support or if the individual lacks capacity to consent, it must be in their best interests to receive such support.

We would require further clarification on this proposal in order to comment more fully. In the Trust's experience, service users who are unable to consent to care and treatment are also generally unable to consent to the appointment of an independent advocate. Individuals following an acquired brain injury are likely to strongly deny that they require an advocate.

Provisional proposal 9-2: the provision of advocacy should be streamlined and consolidated across the Care Act and Mental Capacity Act (in its entirety), so that Independent Mental Capacity Advocates would be replaced by a system of Care Act advocacy and appropriate persons.

In principle we would support this and believe it is an area worthy of further consideration. However, our experience of Independent Mental Capacity Advocates is that their knowledge and expertise can vary significantly, and a more rigorous and streamlined approach, with provision made for training and appeals would be welcomed.

Provisional proposal 9-5, provisional proposal 9-6, provisional proposal 9-7, provisional proposal 9-8:

We would require further clarification on these proposals. Following the introduction of the AMCP role, which already looks at best interests, the role of the Relevant Person's Representative would seem to have been rendered obsolete. Equally, many aspects of the role would be covered by that of the advocate. It is unclear at present how these roles would interact with or overlap with each other.

Provisional proposal 12-1: a new legal process should be established under which a person can appoint a supporter in order to assist them with decision making. The supporter must be able, willing and suitable to perform this role. The Approved Mental Capacity Professional (currently best interests assessor) would be given the power to displace the supporter if necessary (subject to a right of appeal).

See responses to 9-1 and to 9-5 – 9-8. It is concerning that people lacking capacity are to be expected to appoint a support to assist with decision making, and, were this to be implemented, it is unclear how this role would interact with the many other proposed supportive roles.

Provisional proposal 12-2: section 4 of the Mental Capacity Act should be amended to establish that decision-makers should begin with the assumption that the person's past and present wishes and feelings should be determinative of the best interests decision.

We strongly disagree with this proposal, particularly the use of the term "determinative". The present wishes and feelings of people deemed to lack capacity should not be used as the deciding factor when considering future care needs. Weight should not be placed on opinions delivered by people who are disoriented in place and time, particularly when these opinions are objectively unreasonable or unachievable.

The present wishes and feelings should certainly be taken into account as part of best interest proceedings, and past wishes and feelings, particularly if made at a time when the person retained capacity, should likewise be noted. However, the expressed current wishes and feelings may not be reasonable or grounded in reality and it would be unwise and potentially extremely unsafe to prioritise these over assessments made by medical and social care professionals. To elevate these wishes and feelings would also be to undermine the extensive expertise and difficult decisions taken to determine an initial lack of capacity.

Provisional proposal 13-1: the ability to consent to a future deprivation of liberty should be given statutory recognition. The advance consent would apply as long as the person has made an informed decision and the circumstances do not then change materially.

We support the promotion of advance decision making, while recognising that this is unlikely to be an issue for many of our own service users, where progressive degenerative conditions from a point of full capacity are rare.

Provisional proposal 14-1, question 14-2, question 14-3:

There is already a significant degree of variation between DoLS teams as outlined in our responses to a number of other proposals. We do not feel it likely that additional regulatory requirements will address the current deficiencies, and many of the existing problems around the DoLS stem from the burdensome quantities of paperwork already in place. We propose a monitoring system whereby failures to comply with agreed timescales or repeated poor performance are more closely regulated, and those bodies engaged in good practice have their reporting requirements reduced. It would be sensible to avoid involving a further regulator outside those proposed in 14-1.

Question 15-3: what are the current difficulties that arise when identifying the supervisory body for the purposes of the DoLS? Are there any current areas that could be usefully clarified under the new scheme?

At present it is extremely difficult logistically, particularly given that the majority of our services take service users from a wide range of Local Authority areas. For people in a community setting it is the funding authority (LA or CCG) who is responsible and not the local DoLS Team. Trying to get funders to accept responsibility can be difficult. A simple one-point referral/registration system might help, and we would welcome a more streamlined system.

Question 15-4: is a fast track determination scheme needed for cases where a person is deprived of liberty and there is a dispute over the person's ordinary residence?

We have no comments to make regarding a proposed fast track scheme, but we have had significant issues with ordinary residence in the past so would welcome a more coherent system to address this.

Question 15-5: should a new criminal offence of unlawful deprivation of liberty be introduced?

We believe that any would-be offences committed in the course of unlawful deprivation of liberty are already adequately covered by existing criminal legislation.

For further information please contact The Disabilities Trust's Policy and Campaigns Manager