

Reviewing Care Plans in the light of recent Care Law on Deprivation of Liberty

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Care providers are being encouraged to review the care of adults who lack capacity in the light of the Supreme Court's judgement in the Cheshire West case. In particular, to review any restrictions that might stop them being "free to leave", or which amount to "continuous supervision and control" (the two key elements of care the Court said constitute deprivation of liberty under the Mental Capacity Act (MCA)).

The Care Quality Commission (CQC) has summarised the purpose of these reviews as "to assess if the restrictions can safely be reduced or the person's capacity enhanced so that they can make relevant decisions for themselves." But what does this mean in practice?

Fundamentally, the challenge seems to be to demonstrate that each user's care plan – and indeed the service as a whole – is based as much as possible on empowerment and respect for autonomy.

+ **Enhancing capacity**

One obvious way in which unnecessary control can creep into care is when carers are taking decisions which users can take themselves.

The first key principle of the MCA is that people should be assumed to have capacity to take a decision unless it is shown they do not. The second is that all practical steps must first have been taken to help them make the decision themselves. It is only where people lack capacity to make their own decision that the MCA lets other people act in their best interests without their permission.

Providers will want to check that care plans properly reflect people's capacity. Capacity is specific to each decision, but care plans probably can, and should, set out the assumptions on which key elements are based. It should be clear, for example, what elements of the care plan are normally expected to be subject to the person's consent on each occasion and what elements are assumed to be matters on which they will not, or not normally, be able to decide whether to consent.

CQC (and, if it comes to it, the courts) will expect the reasons for these assumptions to be documented, in other words, the assessments of capacity on which they are based. The more important the decision, the more formal the assessment expected. So, for example, if a care plan includes an assumption that the person should be stopped if they try to leave, there needs to be a properly reasoned and documented assessment of why the person is thought to lack capacity to decide whether to stay or leave. Simply noting they have nowhere else to go, say, or that "it wouldn't be safe" would not be enough, because what matters is whether they have the



mental capacity to make the decision, not whether it would be a wise one.

Providers will also want to make sure people are getting help to make their own decisions and that this, too, is part of the care plan. Support easily slips over into control if people aren't given the time they need to make their own decisions, or are presented with choices in ways they cannot easily understand. The Social Care Institute for Excellence says one sign of service that is truly respecting its users' dignity is that staff "value the time spent supporting people with decision-making as much as the time spent doing other tasks."



Supporting people to make their own decisions can also be about helping them learn to take decisions. Last year, the High Court commended the approach taken by a local authority in the case of a sexually active young man with learning disabilities. When doubts were raised about his capacity to consent to sex, it put in place an individualised programme of sex education to help him acquire the capacity he needed. It should also be remembered that even if people lack capacity to take their own decisions, the MCA says they must still be encouraged and helped to participate in the decision-making.

+ Reducing restrictions

The fifth key principle of the MCA is that when deciding what is in the best interests of someone who lacks capacity, regard must always be had to whether there is a less restrictive alternative, meaning an equally effective way of achieving the intended purpose which is “less restrictive of a person’s rights and freedom of action”.

“Rights” is a broad concept. It includes the rights guaranteed to everyone under the Human Rights Act. More broadly, it can be thought of as including those things which people can decide for themselves if they have capacity. So washing someone’s hair can restrict their right to decide who touches them. 1:1 observation can restrict someone’s right to be alone. Limits on visitors and visiting times can restrict their right to determine their own social life.

“Freedom of action” clearly covers things like going where you want, or doing what you want to do without interference. But it is also possible to restrict people’s freedom of action by limiting the range of options available to them - The more choices available in practice, the greater the freedom of action. The fewer choices, the more freedom of action is restricted. And every time you take a decision for someone else, you are exercising a form of control over them and so potentially restricting their freedom of action, even if they aren’t objecting or resisting.

Restrictions on a person’s freedom of movement are defined by the MCA as “restraint”. So is any kind of physical force,

or the threat of it, used to do something the person is resisting? The MCA sets a special threshold for restraint, not only must it be in the best interests of the person who lacks capacity, it must be necessary to prevent the person concerned coming to harm, and be proportionate to the likelihood and seriousness of that harm.

But finding the least restrictive alternative is not just a matter of avoiding unnecessary restraint. It is more general than that, about empowerment rather than control, support rather than supervision. So a key part of any review will be to look at care plans to ensure that any restrictions involved are truly necessary and in the person’s best interests.

The courts have emphasised that this includes considering things from the person’s own perspective. Restriction can be in the eye of the beholder. Staff may think they are just being helpful, when users feel controlled.

Staff may think that someone is free to do something because “all they have to do is ask”, while the person concerned is thinking “why do I have to ask, why can’t I just do it?” Staff might think “I make it easy for her to get dressed by asking her in the evening what she wants to wear tomorrow, and then laying out his clothes for her”, while the user is thinking “She always makes me decide the night before, so I never get to choose what I want to wear on the day”.

As with any best interests’ decision, appropriate involvement of family and friends is also important. The case-law suggests that when “the authorities” (be it providers, commissioners, or individual professionals) proceed on the basis that “we know best”, ignoring or under-valuing other people’s perspectives, the risks of unlawful deprivation of liberty rise significantly.

There will be some restrictions which are fairly obvious. Things like:

- locked doors, or standing instructions to stop people going out, or leaving
- Any kind of physical restraint (including bed-rails or special clothing)
- deciding when people can or cannot do things (like getting up, cooking, using recreation facilities)
- Limits on where and when people can come and go, or taking them to places whether or not they want to go
- keeping people under direct observation even if they don’t want it
- Limits on contact with family, friends or other people
- Medication (especially “prn” medication) specifically used to manage people’s behaviour
- Seclusion, “time-outs” or similar strategies

But there may be less obvious restrictions, for example:

- Staff routines – does the way the service is organised require users to fit their lives around the routine of staff rather than the other way?
- Physical environment – are people allowed, and enabled, to organise their living environment the way

they want? Are there limits on what possessions they can keep (or on their access to them)?

- staff attitudes – are staff trained and encouraged to see themselves as enablers and supporters, rather than as exercising control?
- Boredom, isolation, under-stimulation – are people being left without enough to do? Are they at risk of losing skills, or missing opportunities to gain them, because they are not being enabled to interact with other people, keep fit and alert, challenge themselves?
- Continuity and choice of support – are people at risk of not having their wishes and feelings understood properly, or reluctant to engage, because there is a lack of continuity in who is supporting them? Or because they aren’t involved in choosing who supports them?

The challenge for providers is to consider whether each restriction is necessary and in the person’s best interests. That means being clear about the purpose of each restriction, and showing they have considered what the practical alternatives might be (unless you can imagine things being different, it is difficult to demonstrate you have identified the best alternative).

Not all practical alternatives will be within providers’ own control. Reviews may well identify, for example, that restrictions are justified at present because someone has nowhere else to go, but would not be justified if alternative accommodation or support could be put in place. In such cases, one of the outcomes of the review might be identifying a need to involve commissioners in a review of the whole approach to the person’s care.

Obviously, too, even alternatives within the provider’s control won’t necessarily be practicable straight away. Some ideal solutions may never be practical, because resources are not unlimited. But providers always need to think about whether resources are being deployed in the best way. Are resources being used on stopping people doing things, when they could be used on helping them to do more?

Are they being used to deal with the consequences of anxiety and frustration, rather than on tackling their causes?

Inevitably, some of the most difficult questions will be about risk. Providers can take heart from the fact that regulators and the courts do not expect them to prioritise physical safety at the expense of everything else - Quite the reverse in fact. They always stress the need to strike a balance. As the judge in a High Court case put it, “What good is it making someone safer if it merely also makes them miserable?” The temptation automatically to wrap people in “cotton wool” is to be avoided, because what they gain in safety, they may well lose in other ways, be it their freedom of action, their emotional satisfaction, or their chance to develop.

Where reviews show deprivation of liberty is needed

The first purpose of these reviews is to avoid deprivation of liberty where it is not necessary. But they are not about reducing restrictions to avoid deprivation of liberty regardless of what is best for the person. Some people’s needs are such that deprivation of liberty is unavoidable - it is just not in their best interests to be free to leave, or to be without continuous supervision and control.

So a second explicit purpose is to make sure that, where it is unavoidable, deprivation of liberty gets the proper legal authorisation under the MCA

But there is also a third purpose – to make sure empowerment remains central to care plans, even where deprivation of liberty is necessary. Few adults can exercise no control at all over their own lives and perhaps even fewer have no views about how they want to live. So within the restrictions that are unavoidable, the task for providers remains to help and support users to be as autonomous as they can be, even when they are legally deprived of liberty.

Will put some on quietly in the back ground. I will definitely be using this DVD regularly in my care setting... I was even asked by one of the patients husbands for the email address of where to get one from! Thank you AgeUK!

To get your free copy of the Fit as a Fiddle DVD go to www.ageuk.org.uk/documents/engb/faaf_dvd_flyer_form.pdf?dtrk=true