HEALTH AND SOCIAL SERVICES DEPARTMENT

CAPACITY LAW

The Chief Minister
Policy Council
Sir Charles Frossard House
La Charroterie
St Peter Port

16th December 2015

Dear Sir

1. Executive Summary

1.1 Capacity is "the ability to make a decision"[1] and more particularly the ability for a person to "make a particular decision or take a particular action for themselves at the time the decision or action needs to be taken"[2].

1.2 Every one of us makes decisions every day of our lives, some of great significance and others of less importance. Although we may seek out further advice, information or support from others in making some of these decisions, most of us are able to take those decisions for ourselves and are therefore said to "have capacity".

1.3 However, some members of our community "lack capacity" to make certain decisions:

- the child who struggles to decide on an important issue due to their age and ongoing development;
- the mature adult who may not be able to express their wishes as e.g. they are in a coma after an accident or they have a severe learning disability;
- the older adult who cannot retain the information necessary for decision-making due to old age or dementia; and
- a person with mental illness who is unable to make decisions regarding treatment of a physical ailment.

1.4 Issues of capacity can therefore not only affect these groups of people but also every family member, carer or other professional who attempts to care for, support and treat them. Furthermore, others who currently have capacity may wish to

[1] Paragraph 4.1. of the Code of Practice Introduction to the Code of Practice for the 2005 Act.
[2] Introduction to the Code of Practice for the 2005 Act.

make provision for a time when they no longer have the ability to take certain decisions for themselves.

1.5 The States, on the recommendation of the Health and Social Services Department ("the Department"), have previously legislated in relation to children (The Children (Guernsey and Alderney) Law, 2008) but the Department has not made any proposals as to how the adults listed in paragraph 1.3 could be assisted to make decisions wherever possible or to ensure responsible decision-making on their behalf where they cannot do so.

1.6 Accordingly, the Department has considered best practice and legislation from other jurisdictions and, although this Policy Letter is informed by the provisions of the Mental Capacity Act 2005 ("the 2005 Act") enacted in England and Wales, the measures set out below are those which it considers would most effectively assist and protect members of the community across the Bailiwick whilst avoiding the bureaucracy and cost of systems adopted by larger jurisdictions.

1.7 The Department therefore proposes to introduce new legislation which reflects the 2005 Act and will:

- state the test for deciding whether or not a person has capacity to take a decision;
- allow a person to appoint another person to act on their behalf if they lose capacity to take decisions;
- allow a person to take legally binding decisions regarding their medical treatment after they have lost capacity;
- state what can be done when a person has lost capacity without appointing another person to take decisions on their behalf or without making legally binding decisions regarding their medical treatment; and
- permit appropriate safeguards for individuals without capacity where their treatment or care requires them to be deprived of their liberty in their best interests.

2. Background

2.1 In November 2013, the States of Guernsey agreed proposals for capacity legislation to be created, following consideration of the Policy Council's report on the Disability and Inclusion Strategy (Billet d'État XXII, November 2013, paragraphs 115-118). Specifically, the States agreed to direct the Department to research and develop options for capacity legislation and to report back on this matter no later than the end of 2016.

2.2 Subsequently, Deputy Perrot submitted a Requête in April 2014 (Billet d'État IX, Volume 2) following which the States directed an investigation into the introduction of lasting powers of attorney.

2.3 This Policy Letter addresses both of those States directions, and also addresses the lack of any legislative protection for those vulnerable people within the Bailiwick who require assistance to make decisions in their own best interests, but who do not fall within the remit of mental health legislation such as the Mental Health Act 1983 and the Mental Health (Bailiwick of Guernsey) Law, 2010 ("the 2010 Law").

2.4 Additionally, it is important to ensure that the human rights of all those who lack capacity are being considered and respected, especially since the incorporation of the European Convention for the Protection of Human Rights and Fundamental Freedoms into domestic law by the Human Rights (Bailiwick of Guernsey) Law, 2000. The absence of such legislation and protection leaves the States open to challenge under Article 5 of the European Court of Human Rights, an occurrence that has resulted in significant financial implications for Jersey.

2.5 The Department therefore considers it appropriate to introduce new legislation which has **the principal purpose of empowering people to make decisions for themselves wherever possible**.

2.6 These issues have been addressed in England and Wales through the introduction of the 2005 Act, which has been widely praised for its positive ethos of encouraging decision-making by the individual rather than simply allowing the views of others to be imposed on a person without capacity. This has therefore informed the content of this policy letter, subject to changes that reflect the unique context of the islands' communities and context, as well as the most recent learning from implementation in the United Kingdom.

2.7 A simple collection of principles underlies all of the proposals outlined, reflecting the approach of section 1 of the 2005 Act and the Department's current approach to capacity. These principles are:

- a person must be assumed to have capacity unless it is established that they lack capacity;
- a person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success;
- a person is not to be treated as unable to make a decision merely because they make an unwise decision;
- an act done, or decision made, under this legislation for or on behalf of a person who lacks capacity must be done, or made, in their best interests; and
- before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

2.8 No person under the age of 18 shall be subject to these proposals and the law in respect of consent to medical treatment or other matters in respect of children under that age will not be affected[3].

3. Basic Principles

3.1 Decision Makers

3.1.1 In different situations, currently individuals such as family members, care professionals, financial advisers and others may provide care or assistance to people who they think may lack capacity to make a particular decision for themselves. These decisions may include day-to-day decisions about what to wear, important decisions about managing money, and even life and death decisions about health care. It is important therefore that a simple but rigorous process for assessing capacity to make a particular decision is at the heart of these proposals. If it is established that a person does not have capacity to make a specific decision, different routes are available to the decision maker who may, for example, have already been given power to make appropriate decisions e.g. in relation to financial matters under a Lasting Power of Attorney (see section 4.3) and under *curatelle* (see section 4.4).

3.2 Assessing Capacity

3.2.1 The Department proposes that the decision maker should employ a simple 2 stage test to assess whether, in relation to any matter, a person is able to make a decision for themselves:

- the diagnostic stage: does the person have an impairment, or a disturbance in the functioning, of the mind or brain (whether or not this is permanent or temporary, and regardless of its cause)?
- the functional stage: is there evidence that the person lacks capacity to make the particular decision at the time the decision needs to be made?

3.2.2 This test is a "decision-specific" and "time-specific" test; no-one should be labelled "incapable" or "incapacitated" as a result of a particular medical condition or diagnosis, whether it is permanent or temporary. It is important to recognise that lack of capacity should not be established merely by reference to a person's age, appearance, or any condition or aspect of a person's behaviour which may lead others to make assumptions about capacity.

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[3] The current approach under The Children (Guernsey and Alderney) Law, 2008 will continue for those under 18 so, for example, the overriding principle that "the child's welfare is the paramount consideration" (s.3(1)(b)) and the principles that "irrespective of age, development or ability, a child should be given the opportunity to express his wishes, feelings and views in all matters affecting him" (s.3(2)(e)) and "except where it is shown to the contrary, it is presumed that a child is capable of forming a considered view from the age of 12 years" (s.3(2)(f)) will still apply.

3.2.3 Under this test a person may have capacity to make a particular decision on a particular day about an aspect of their care and welfare, but may not have capacity to make a decision on that same day about an aspect of their financial affairs.

3.3 Diagnostic Stage

3.3.1 The most common medical reasons for which it is considered that a person has an impairment or disturbance in the functioning of the mind include:

- dementia;
- coma;
- stroke; and
- severe learning disability.

3.3.2 However, it is also possible for others temporarily to fall into this category due to intoxication through drink or drugs, or acute confusion due to physical illness.

3.4 Functional Stage

3.4.1 The Department proposes that a person may be treated as lacking the capacity to make a particular decision if there is evidence that the person is unable to do one or more of the following in relation to that decision:

- to understand the information relevant to the decision (provided that it has been explained in a way that it's appropriate to the individual and the circumstances e.g. using simple language, visual aids or any other means);
- to retain that information for an appropriate period (dependent on the nature and implications of the decision to be made);
- to use or weigh that information as part of the process of making the decision; or
- to communicate their decision, whether by talking, using sign language or any other means.

3.4.2 The Department also considers that a person should not be treated as unable to make a decision merely because they would make an unwise decision. Therefore, evidence that the person would or may make an unwise decision will not of itself be conclusive that the person lacks capacity to make the decision.

3.4.3 When assessing a person's capacity to make a particular decision (along with any other assessment or decision under the proposed legislation), the decision maker should weigh the evidence and make a decision on the balance of probabilities i.e. it is more likely than not. If the decision maker concludes that it is more likely than not that the person lacks capacity to make a decision, that person is to be taken as not having capacity in relation to that decision.

3.4.4 Even where a person does not have capacity, they should in any event be given all appropriate help and support to enable them to maximise their participation in any decision-making process.

3.5 Best Interests

3.5.1 If a person does not have capacity to make a particular decision, the Department proposes that, before the act is done or a decision is made on their behalf, the decision maker should establish what is in the person's best interests and act accordingly.

3.5.2 In establishing what is in a person's best interests, it will be important that assumptions are not made about the person by the decision maker on the basis of the person's age or appearance or any aspect of their condition or behaviour. Instead, the decision should reflect the wishes and feelings of the person affected when they had capacity. Therefore, the Department considers that the proposed legislation should include express provision outlining the factors that decision makers may consider when making best interests decisions.

3.5.3 When deciding what is in the best interests of a person, the decision maker should consider all the relevant circumstances and, where it is reasonably practicable to do so, encourage the person to participate as fully as possible in the decision making process. Therefore, the best interests of a person should be determined with particular regard to:

- whether it is likely that the person will at some time have capacity in relation to the matter in question, and when that may be;
- the person's past and present wishes and feelings, which may include any relevant written statements made before they lost capacity;
- the beliefs and values that would be likely to influence their decision;
- other factors that they would be likely to consider if they were able to do so; and
- whether the purpose for which a decision is being taken can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

3.5.4 Where practicable and appropriate, the decision maker may take into account the views of others who know the person when considering what would be in that person's best interests. In particular, the decision maker would look to discover any wishes, feelings, beliefs and values previously expressed by that person. The individuals consulted may include anyone named by the person, anyone involved in caring for them, anyone who has had a lasting power of attorney granted to them and any guardian. Due consideration would have to be given to confidentiality when this consultation took place. The decision maker may also need assistance from an independent person or body where the decision is a complex one.

3.5.5 The decision maker may also, where appropriate, be supported by an advocacy worker who will give an independent view in relation to the most significant decisions that may have to be made.

3.6 Excluded Decisions

3.6.1 It is recognised that some decisions should never be made on behalf of a person who lacks capacity because:

- those decisions are peculiarly personal to the individual, such as entering into or ending a marriage, conducting a sexual relationship, changing domicile, making a will, voting, consenting to the adoption of a child, discharging parental responsibilities in relation to matters other than a child's property; or
- other legislation already governs those decisions, where e.g. they concern treatment for mental disorder under the provisions of the 2010 Law.

3.7 Legal Protection for Decision Makers

3.7.1 The Department proposes that, as well as protecting the rights of persons who may lack capacity, the new legislation should provide greater legal protection for decision makers working with them. Therefore, it will be lawful for a decision maker to proceed as if the person had consented to the act if the decision maker considers on the balance of probabilities:

- after taking reasonable steps to establish whether a person has capacity, that the person does not have it, and
- that a particular course of action is in that person's best interests.

3.7.2 No legal liability will arise for the decision maker by virtue of the lack of consent, though they may still be liable in the normal way for loss or damage for negligence for the manner in which they carry out the act. In addition, if concerns are raised over the decision maker's acts and the safety of the person lacking capacity, a safeguarding referral may be made to the Department in order to protect that person from harm.

3.8 Wilful Neglect and Ill Treatment

3.8.1 There have been a number of cases in the United Kingdom[4] and Jersey[5] where the wilful neglect and abuse of vulnerable persons has caused harm. In Guernsey, section 85 of the 2010 Law makes it an offence for workers or others who have

[4] A high profile example was the *Winterbourne View* case, involving abuse and neglect in a residential care home.
[5] *AG v Breen* [2011] JRC057.

custody or care of patients under that Law to mistreat them[6]; however, this offence does not apply to those who are not subject to the 2010 Law.

3.8.2 With this in mind, the Department proposes to create a new, free standing offence to cover wilful neglect and abuse that applies to the treatment of people (i) living in care homes, or (ii) provided with domiciliary care or supported living arrangements.

4. Planning for the Future

4.1 Introduction

4.1.1 In keeping with the ethos of empowerment reflected in these proposals, the new legislation will make provision to ensure that everyone who currently has capacity can plan for a time when they may not do so. The Department proposes that this planning may take two forms:

- an Advance Decision to Refuse Treatment ("ADRT"), which could be made by a person with capacity to prevent the giving of a particular treatment in the future if they do not have capacity; and
- a Lasting Power of Attorney ("LPA"), which could be made to determine who is entitled to make certain types of decisions for a person, particularly when they lack capacity.

4.2 Advance Decisions to Refuse Treatment

4.2.1 There has been some uncertainty in Guernsey over the legal enforceability of advance decisions regarding treatment and whether a particular form or procedure must be used in order to confer validity on a person's wishes. The Department accordingly proposes that the new legislation should set out a clear process to be followed to create an ADRT (otherwise known as a living will or an Advance Directive) which would allow a person who currently has capacity to make a decision refusing specified future treatment when that person may no longer have capacity to decline it.

4.2.2 As the authority for these decisions is derived from "*the established legal right of competent, informed adults to refuse treatment, irrespective of the wisdom of their judgement*" (British Medical Association, 1995), the best interests principle does not apply to ADRTs. Medical professionals must therefore comply with a valid ADRT, even if they do not consider that it would be in the service user's best interests to do so.

4.2.3 It is further proposed that it is the responsibility of the person who wishes their ADRT to be followed to bring this decision to the notice of services likely to be

[6] A further offence was created in the *Loi relative à la protection des femmes & filles mineures, 1914* in relation to having sexual intercourse with a woman or girl of unsound mind (article 3). It is anticipated that the new sexual offences legislation will repeal and replace this offence in due course.

involved in their care in the future. However, where an ADRT is brought to the attention of the appropriate officials in the Department, it will be the Department's responsibility to note the ADRT and ensure that it is communicated to front line care teams.[7]

4.2.4 To avoid unnecessary complication, the Department suggests that no particular formalities should be required to make an ADRT in most cases and equally that it should be possible to withdraw an ADRT without any formality. However, the ADRT would not apply until the person loses capacity to consent to treatment and it must be specific about the treatment and circumstances to which it applies.

4.2.5 However, the Department proposes that strict formalities must be complied with where an ADRT concerns treatment which, in the view of the person providing healthcare for the person concerned, is necessary to sustain life. These formalities are that the ADRT must be in writing, signed and witnessed. In addition, there must be an express statement that it stands "even if life is at risk" which must also be in writing, signed and witnessed.

4.3 Lasting Powers of Attorney

4.3.1 The Department proposes that, like the United Kingdom, the provision for LPAs should allow a person (the "donor") to appoint another (the "donee") to make decisions on the donor's behalf. In order to make a valid LPA, the donor would need to have capacity to make the decision to appoint a donee when the appointment is made.

4.3.2 A donee will have the delegated power to make decisions on behalf of the individual in line with their beliefs and wishes. The Department proposes that there should be two types of LPA and that a person may choose to make either or both types and may appoint a different person as donee in each case. The two types of LPA will be (i) health and welfare, and (ii) property and financial affairs.

4.3.3 A health and welfare LPA would allow a donor to choose a donee to make decisions about things like their daily routine (e.g. what to eat and what to wear), medical care, moving into a care home and life-sustaining treatment. This type of LPA would not have any practical effect until such time as the donor loses capacity to make their own decisions.

4.3.4 A property and financial affairs LPA would allow the donor to choose a person to make decisions about money and property, such as paying bills, collecting benefits and selling assets such as the donor's home. This type of LPA could potentially be used while the donor still has capacity, if permission is given in the LPA for that to happen.

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[7] Should this be approved, the legal framework and related procedures would need to be thoroughly understood, applied, and audited. It would then be covered in the training to be provided to support implementation.

4.3.5 A donee may be appointed to act alone or jointly with another person. A person may also appoint more than one person as donee, but allow each of them to act separately (which may be appropriate where the person is unsure which of their donees will be available to act at a given time). The donor should also be able to stipulate that there are some matters in respect of which a donee must act jointly and others where they may act alone. Where donees are appointed jointly, or different donees are appointed under a health and welfare LPA and a property and financial affairs LPA, they would be under a duty to act in consultation and cooperation with one another, with provisions for application to a court if agreement could not be reached.

4.3.6 As the exercise of an LPA could have significant effects, there needs to be appropriate safeguards placed on the creation of LPAs. At the same time, it is important not to make these too burdensome or expensive as this may discourage people from making LPAs.

4.3.7 In the United Kingdom, an application for a LPA needs to be witnessed and, once the LPA has been completed, an application needs to be made to the Office of the Public Guardian, to register the LPA. In the United Kingdom it costs £110 to register a LPA and therefore £220 if a person wishes to register both a health and welfare LPA and a property and financial affairs LPA. Furthermore, as the forms used to appoint an attorney and register the LPA are complex, it is often the case that a person will need the assistance of a legal professional in order to complete the process. According to the Lords Select Committee Report, there is evidence that in the United Kingdom the complexity and expense of registering an LPA has had a negative impact on the number of people using them[8].

4.3.8 So far as it is possible to do so, the Department will look to streamline the process for making an LPA whilst ensuring that appropriate safeguards are in place. The proposed procedure would therefore include the following steps:

- an LPA would need to be registered by the donor in person when it is made (in order to prevent 3rd parties from registering false LPAs or persuading vulnerable donors to make LPAs in the 3rd party's favour);
- the LPA would be registered by Her Majesty's Greffier, the Alderney Greffier or the Seneschal (which would allow an independent person to ask basic questions so that any concerns over capacity could be raised immediately);
- the registration form would be similar to a passport application form and would require the signature of a counter-signatory who had met the donor recently and did not have any concern over that person's capacity to make an LPA (so as to ensure that the donor has the capacity to make a valid LPA but without the necessity of a medical practitioner's certificate to that effect); and

[8] Paragraph 182.

- the registration form would also include the details of 2 people, for example a family member and a close friend, to be notified of the LPA's registration (which would allow enquiries to be made if the donor might already have lost capacity, the making of the LPA was unexpected or an unsuitable donee had been chosen).

4.3.9 While such a procedure would by its nature be bureaucratic, it would afford an important opportunity to challenge inappropriate LPAs or resolve disputes about the terms of the LPA while the donor still has capacity. If there were any concerns which needed investigation, the Department Safeguarding Team (rather than the person raising the issue) would be responsible for making enquiries. There would be a cost of registration which would be passed on to those benefitting from LPAs in the form of an affordable fee. Furthermore, the Department proposes that a donor should be able to make both types of LPA on the same occasion and, if the donor, the donee(s) and the 2 persons to be notified are identical for both, only one fee should be payable.

4.3.10 If and when the donor lost capacity, the donee would be required to activate the LPA (unless the donor had already given permission in relation to a property and financial affairs LPA). The LPA would, in a similar way to the original registration, be activated by Her Majesty's Greffier, the Alderney Greffier or the Seneschal, thereby ensuring an independent check.

4.3.11 It is proposed that activation of the LPA would involve:

- a signature from a medical professional involved in the donor's care, such as a GP or a nurse, to state that the donor no longer had capacity (to ensure that an independent view is given rather than that of e.g. a family member); and
- the notification of the 2 people previously notified on registration of the LPA (which would again allow enquiries to be made for similar reasons as found in para. 4.3.8).

4.3.12 This process should save time and expense in the long term. However, the Department recognizes that it will be important to ensure the making, registering and activating an LPA is sufficiently simple that it can be completed by most people without the help of a professional adviser.

4.3.13 In order to simplify the position of a person who lives or holds property in other jurisdictions in the British Islands, the Department will also work towards attaining full recognition of an LPA validly made in Guernsey regarding care or assets on the mainland and the Crown Dependencies.

4.4 Guardianship

4.4.1 At present, where a person lacks capacity to deal with their own affairs, the Royal Court can be asked to make a one-off decision in relation to a specific issue or to

place the person under *curatelle* (customary law guardianship). The Department recognises the flexibility and continued usefulness of *curatelle* and therefore does not propose to introduce any new form of guardianship at this stage; it would nevertheless support any moves by the Royal Court to develop further the rules and practice regarding *curatelle*.

5. Deprivation of Liberty[9]

5.1 Introduction

5.1.1 It is now settled law that a person may be deprived of their liberty for the purposes of Article 5 of the European Convention on Human Rights where:

- that person is confined in a particular restricted place for a not negligible length of time;
- that person does not give valid consent to the confinement; and
- the confinement is attributable to the State.

5.1.2 Where the confinement is attributable to the State, it has recently been decided by the United Kingdom Supreme Court in *Cheshire West*[10] that a person will be deprived of their liberty when they:

- are placed under continuous supervision and control; and
- are not free to leave.

5.1.3 An order for detention under the 2010 Law and a sentence of imprisonment passed by a criminal court give legal authority for a deprivation of liberty to take place.

5.1.4 In the context of a person who lacks capacity, a deprivation of liberty could take place where the professionals caring for and managing that person exercise complete and effective control over that person's care and accommodation. The decision of the European Court of Human Rights in *HL v United Kingdom*[11] led to the introduction of statutory Deprivation of Liberty Safeguards ("DoLS")[12] in England and Wales as part of the 2005 Act; these provide legal protection for those vulnerable people who are, or may be, deprived of their liberty. The purpose of DoLS is to secure independent professional assessment of: (a) whether the person concerned lacks the capacity to make their own decision about where to

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[9] Whilst this is the terminology used e.g. in England and Wales, the Department intends to consult further on the use of this term to ensure the most appropriate language is used to reflect the nature of the protection offered.

[10] *P (by his litigation friend the Official Solicitor) (Appellant) v Cheshire West and Chester Council and another (Respondents); P and Q (by their litigation friend, the Official Solicitor) (Appellants) v Surrey County Council (Respondent)* [2014] UKSC 19, paragraph 49. Although this judgment is not binding on the Bailiwick, the members of the Supreme Court also sit on the Judicial Committee of the Privy Council and therefore account should be taken of this decision.

[11] (2004) 40 EHRR 761.

[12] See, for example, Schedule A1 of the 2005 Act.

be accommodated, the treatment or care to be given etc., and (b) whether it is in that person's best interests for the deprivation to take place.

5.1.5 Although the United Kingdom has addressed the issues raised by the decision in *HL*, there has been a great deal of criticism of the DoLS regime in England (collated in the report published by the House of Lords Select Committee on the Mental Capacity Act 2005[13]("The Lords Select Committee Report")) due to its complexity and limited application as it does not apply to placements outside hospitals and care homes. There has also been confusion about how the regime should be applied in combination with detention powers in mental health legislation.

5.1.6 The Department recognises that, as in England and Wales, it might sometimes be necessary to care for persons who lack capacity in circumstances that deprive them of their liberty. Appropriate statutory safeguards appropriate to the size and administrative resources of the Bailiwick will therefore be introduced to authorise these deprivations of liberty and to making arrangements so that such deprivations can be challenged. However, the Department is determined that lessons should be learned from the difficulties experienced with the DoLS framework under the 2005 Act and that the system should be appropriate to the size and administrative resources of Guernsey.

5.1.7 It should also be recognised at the outset that it will neither be necessary nor appropriate to formally authorise a deprivation of liberty in respect of every person who is cared for in a residential care home for the elderly or in a home for people with learning difficulties, as many will have capacity to decide where they should be cared for and others may not be deprived of their liberty.[14]

5.2 Proposals for a DoLS Framework

5.2.1 The Department's current range of proposals include a streamlined version of the system found in England and Wales, as well as a system of authorised establishments in which authorisation to deprive a person of their liberty could be given.

5.2.2 The main points of the proposed framework include:

(a) "Authorised establishment": the Department is currently considering the arrangements for the regulation of care quality and the need for an 'independent' or 'quasi-independent' body to support the legislation

[13] Mental Capacity Act 2005: post-legislative scrutiny, Chapter 7 (and in particular paragraphs 271-272).
[14] The issue of the threshold for determining that a person is being deliberately deprived of their liberty is one that will be developed and agreed across professionals and in further consultation with the Royal Court in the drafting of the legislation itself, and the policy and practice guidance underpinning it. It is not intended, for example, that every person with advanced dementia who is living in a care home, and who occasionally attempts to leave, would need to be subject to DoLS.

relating to this. This will be the subject of a future Policy Letter.[15] For the purposes of this Policy Letter these arrangements are referred to as the "Care Regulation Commission", although the title may change. The CRC, or similar, would authorise establishments to have the legal ability to deprive people of their liberty. Authorised establishments for the purposes of the proposed legislation would include hospitals, approved establishments under the 2010 Law, nursing homes, care homes and supported living schemes (including extra care accommodation and learning disability homes). Before authorisation could take place, the establishment would have to comply with standards and expectations set out by the CRC in relation to its physical environment and care processes.

(b) "Immediate authority to deprive": where an authorised establishment believed that it was urgently necessary to deprive a person in its care of their liberty, the senior member of staff (who would be registered with the CRC after receiving appropriate training) would grant an immediate authority to deprive that person of their liberty for a period of up to 72 hours. After granting an immediate authority, the senior member of staff would then be required to both (i) notify the CRC and a member of the person's family of the grant of the authority to deprive, and (ii) arrange for a medical practitioner to visit the authorised establishment during that period to carry out a capacity assessment and mental health assessment on that person.

(c) "Interim authorisation": where a medical practitioner subsequently carried out assessments under an authority to deprive and decided that the deprivation of liberty is or may be necessary, that medical practitioner could then grant an interim authorisation which authorised the deprivation of liberty for a period of up to 14 days (commencing when the authority to deprive was granted). The purpose of the interim authorisation would be to allow an application to be made to the CRC for a standard authorisation. After granting an interim authorisation, the medical practitioner would be obliged to notify the CRC and the person's nearest relative of that grant.

(d) "Standard authorisation": where either (i) a medical practitioner notified the CRC of the grant of an interim authorisation, or (ii) an authorised establishment notified the CRC that it wished to deprive a person of their liberty other than under an immediate authority or interim authorisation, the CRC would send a Care Coordinator (who would be a health or social care professional[16]) to carry out a best interests assessment on the person in order to decide whether any arrangements proposed which would deprive them of their liberty would be necessary and in their best interests. The Care Coordinator would require evidence from a medical practitioner

[15] Pending this Policy Letter being considered by the States, for the purposes of DoLS, interim oversight will be provided within HSSD, and resourced as part of the overall transformation programme for Health and Social Care

[16] They would usually be an occupational therapist, nurse or social worker.

that the person did not require an assessment for mental disorder, if that evidence had not been provided by the medical practitioner when an interim authorisation was granted. Where the Care Coordinator decided that an application for a standard authorisation should be made, the Care Coordinator would apply to the CRC for the grant of that authorisation. Where the CRC decided that it is necessary and in the patient's best interests for a standard authorisation to be granted, it could grant an authorisation for up to 6 months, which could be renewed on application to the CRC by the Care Coordinator for an initial period of 6 months and thereafter for subsequent periods of 12 months.

(e) Visits to authorised establishments: where a standard authorisation were to be in force, (i) the Care Coordinator would visit the authorised establishment regularly in order to monitor the terms and exercise of the standard authorisation, and (ii) the CRC would ensure that inspection visits are carried out on the authorised establishment at intervals of not more than 6 months.

(f) Review of authorisations: if the person subject to an authorisation (or a relative) wished to challenge the grant of that authorisation, that person could apply to the CRC to discharge an interim authorisation or the Royal Court to discharge a standard authorisation.

5.2.3 To avoid duplication of resources, the Department proposes to integrate the process for authorising deprivations of liberty with the new arrangements being put in place for the assessment and monitoring of long term care provision generally. It is intended that this process would capture the majority of the persons who may be deprived of their liberty, but provision should also be made to ensure that it is possible to authorise deprivations both: (i) when they arise between assessment and monitoring cycles and (ii) when they arise in situations in which those cycles are not applied.

5.2.4 In addition to the recommended procedure set out above, there should be a right for any person, including a care worker or family member, to request that a best interests assessment is carried out by the Care Coordinator. It is proposed that where such a request is made and a standard authorisation might be appropriate, the Care Coordinator should carry out the assessment within 5 working days.

5.2.5 In response to the Lords Select Committee Report suggesting reform of the DoLS framework, the Law Commission of England and Wales was requested to review the current provisions of the 2005 Act and suggest any amendments which could be made. Accordingly, the Law Commission has recently published a consultation document[17] moving away from the original approach and instead introducing new concepts of protective care and restrictive care and treatment. The Department

[17] Mental Capacity and Deprivation of Liberty; Consultation Paper No. 222.

will carefully monitor the comments made to the Law Commission, along with the conclusions reached by it, in order to inform the drafting of the legislation.

6. Restraint

6.1 Restraint is considered to be the use or threat of force where a person who lacks capacity resists, and any restriction of liberty or movement regardless of whether the person resists. It will therefore include situations where carers physically restrain a person from doing something or tell them that they will do so if they try.

6.2 The proposed legislation will permit a person to use restraint where:

- that person reasonably believe it is necessary to prevent harm to the person who lacks capacity; and
- the restraint used is a proportionate response to the likelihood and seriousness of the harm.

6.3 This provision will provide assurance to care professionals where they are caring for a person in a way which is consistent with current best practice, and that reflects the States policy and guidance on the method of restraint to be used to ensure that individuals are not harmed or injured should physical intervention be necessary.

7. Consultation

7.1 In developing the proposals contained in this Policy Letter, the Department has consulted with representatives of the States of Alderney and the Chief Pleas of Sark, the care home sector, voluntary organisations (including MIND, the Alzheimer's Society and MENCAP), service users and carers, the Royal Court and the Guernsey Bar, General Practioner practices in Guernsey, the Disability and Inclusion Strategy Steering Group (DISSG), the Policy Council, other States Departments (including the Home Department and the Social Security Department), Guernsey Police, St. John’s Ambulance, the Probation Service, the Department's older age psychiatrists, and the Legal Aid Administrator. This included discussion about the potential resource implications of the legislation and its implementation, based on an understanding of the costs and impact in Jersey and in England and Wales.

7.2 The Department has also consulted with the Law Officers of the Crown during the development of this Policy Letter, and their comments and views are incorporated.

8. Resources

8.1 The Department will carry the greatest resource burden in the implementation of the new Law, although there will be some, albeit small, implications for other Departments, such as Home, where the Police will be required to investigate the

new offence of wilful neglect, for example. However, the anticipated volume is small and this is not therefore expected to be resource intensive and can be absorbed in core business.

8.2 Costs for the administration of the LPA will be met by the charges for this service set by the Greffe, which will administer them. The main additional funding required will be to meet the additional administrative, assessment and regulatory implications. As stated previously (paragraph 5.2.2 (a)), the latter is an issue for further detailed review and a future Policy Letter, but will be considered as part of the transformation of health and social care through 2016 - 17.

8.3 Whilst it is planned to absorb the Department's costs of implementation within the Department's existing budget, these costs are not insignificant and are therefore set out below to highlight the additional pressures that will need to be considered through departmental re-profiling as part of the transformation of Health and Social Care. They are estimated based on the experience of implementation of Capacity Law elsewhere, including in Jersey, and whilst these costs will require further detailed work, they will be cost neutral for the Department in year one.

	2016	**2017**	**2018**	**2019**
Advocacy workers		£20,000	£60,000	£60,000
LPA Clerk		£10,000	£20,000	£20,000
DoLS Administrator		£20,000	£40,000	£40,000
Best Interest Assessors (existing social work and OT staff)		£40,000	£90,000	£90,000
Training		£25,000	£10,000	
Implementation Project Manager	£35,000	£35,000	£10,000	
Annual Total	**£35,000**	**£150,000**	**£230,000**	**£210,000**

8.4 Costs for 2017 are being considered as part of the ongoing redesign of Mental Health Services within the new Oberlands development. This will include the use of existing vacant social worker posts and draw upon other changes identified through the planned diagnostic of adult social care services which will take place in early 2016. In turn, this will inform the transformation programme and the 2017 Budget for health and social care.

8.5 However, it is important to note that the new Law is unlikely to be fully enacted until 2018, and future costs can only therefore be estimated at this stage. However, this lead in time gives the new Committee *for* Health and Social Care time to review priorities and to consider proposals for how service re-profiling will meet

the costs of this legislation in future years. Within this context, service provision will not be made beyond the ability of the Committee *for* Health and Social Care to prioritise and to make the required funding available.

8.6 The Policy Council and the Legal Aid Administrator have also pointed out the potential impact on the Legal Aid budget, but advise that it is impossible to predict the detailed cost implications until the new Law is drafted. In due course, the Committee *for* Health and Social Care will, therefore, need to liaise with the Committee *for* Employment and Social Security - which will be responsible for Legal Aid under the new system of government - to consider, in line with the relevant human rights obligations, what areas of the new law should fall within the scope of Legal Aid funding; in particular, whether certain aspects of it, such as deprivation of liberty, should be assessed on a "no means, no merits basis". Careful further analysis is likely to be required in order to ascertain the full implications of the proposals on the Legal Aid budget once the new Law has been drafted. Accordingly, the Committee *for* Health and Social Care should present the results of this analysis to the States before the legislation itself is presented for approval.

9. Conclusions

9.1 In order to protect and empower vulnerable members of our community, the Department considers that it is important to introduce new legislation, supported by underlying policies and procedures, which will facilitate decision making by individuals for the present and the future. These proposals aim to provide clear and efficient pathways, tailored to the needs of the Bailiwick, for this to happen. (N.B. Deputy Hadley has asked that it be recorded that he does not support the proposals.)

10. Recommendations

The States are asked:

1) To approve the proposals set out in this Policy Letter, and specifically to approve:

   a) the introduction of a general capacity test (sections 3.2-3.4);

   b) the exclusion from the legislation of the decisions listed in paragraph 3.6.1;

   c) the introduction of legal protection for decision makers on the basis set out in section 3.7;

   d) the creation of a criminal offence of wilful neglect and ill treatment (section 3.8);

e) the creation of statutory Advance Decisions to Refuse Treatment (section 4.2) and Lasting Powers of Attorney (section 4.3); and

f) the introduction of Deprivation of Liberty Safeguards as proposed in section 5.2.

2) To direct the preparation of such legislation as may be necessary to give effect to the above decisions.

3) To note the additional resources required from 2017 to support the implementation of this legislation, which will be prioritised as part of the transformation programme for Health and Social Care.

4) To note the potential impact on the Legal Aid budget, and to direct the Committee *for* Health and Social Care to report to the States on this issue when the implications are clearer and before the legislation is presented to the States of Deliberation for approval.

Yours faithfully

P A Luxon
Minister

H J R Soulsby
Deputy Minister

S A James MBE
M K Le Clerc
M Hadley

R H Allsopp OBE (Non-States Member)
A Christou (Non-States Member)

(N.B. The Treasury and Resources Department notes that there are resource implications relating to implementation (including training) and staffing as a result of the recommendations of the Policy Letter. It is the intention of the Health and Social Services Department and subsequently the Committee *for* Health and Social Care to manage the resource implications within their existing resources as highlighted:

- **in paragraph 8.3 where it is stated that the Health and Social Services Department plans to "*absorb*" the costs of implementation "*within the Department's existing budget*",**

- **by the commitment made in recommendation 3 where resource requirements from 2017 onwards will be "*prioritised as part of the transformation programme for Health and Social Care*" and,**

- **in paragraph 8.5 where it is stated that "*service provision will not be made beyond the ability of the Committee for Health and Social Care to prioritise and to make the required funding available*".**

It is expected that any resource implications that arise in the future are managed by the Committee *for* Health and Social Care in a manner that is consistent with the wider reform of Health and Social Care and the outcomes and actions of the recent BDO Benchmarking Report.

The Treasury and Resources Department also notes that there are expected to be financial implications related to the provision of Legal Aid services and that, in accordance with recommendation 4, the Committee *for* Health and Social Care will report to the States on this issue "*when the implications are clearer and before the legislation is presented to the States for approval*". However, it should be pointed out that any increase in expenditure on the formula-led Legal Aid heading will inevitably result in reduced budget being available for other services.)

(N.B. A key workstream in the Disability and Inclusion Strategy approved by the States in November 2013, the introduction of this legislation will make a valuable contribution to the measures necessary to safeguard the interests of vulnerable adults in our islands.

The Policy Council, therefore, supports these proposals and is satisfied that they comply with the Principles of Good Governance as defined in Billet d'État IV of 2011.)

The States are asked to decide:-

III.- Whether, after consideration of the Policy Letter dated 16th December, 2015, of the Health and Social Services Department, they are of the opinion:

1. To approve the proposals set out in that Policy Letter, and specifically to approve:

   a) the introduction of a general capacity test (sections 3.2-3.4),
   b) the exclusion from the legislation of the decisions listed in paragraph 3.6.1,
   c) the introduction of legal protection for decision makers on the basis set out in section 3.7,
   d) the creation of a criminal offence of wilful neglect and ill treatment (section 3.8),
   e) the creation of statutory Advance Decisions to Refuse Treatment (section 4.2) and Lasting Powers of Attorney (section 4.3), and
   f) the introduction of Deprivation of Liberty Safeguards as proposed in section 5.2.

2. To direct the preparation of such legislation as may be necessary to give effect to the above decisions.

3. To note the additional resources required from 2017 to support the implementation of this legislation, which will be prioritised as part of the transformation programme for Health and Social Care.

4. To note the potential impact on the Legal Aid budget, and to direct the Committee *for* Health and Social Care to report to the States of Deliberation on this issue when the implications are clearer and before the legislation is presented to the States for approval.