Final Business and Regulatory Impact Assessment

Title of Proposal

Draft Adults with Incapacity (Scotland) Bill

Purpose and intended effect

- **Background**

After the case of *HL v United Kingdom* (2005) 40 EHRR 32, commonly referred to as the "*Bournewood* case", it was considered that detaining adults lacking capacity to consent to their living arrangements in hospitals and care homes without any lawful process might be contrary to the right to liberty and security (Article 5 of the European Convention on Human Rights). In summary the *Bournewood case* determined that the admission to a psychiatric hospital and continued detention there of a person with learning difficulties such that he could not consent to being where he was, represented a deprivation of liberty. It could not be classed as "voluntary" and needed to take place in accordance with a procedure prescribed by law in order to comply with Article 5 of the ECHR.

As Scots law stands at present there are various statutory procedures which operate in this context. These include a power to help adults lacking capacity to benefit from social services under section 13ZA of the Social Work (Scotland) Act 1968, adult protection measures under the Adult Support and Protection (Scotland) Act 2007, as well as appointment of a guardian under the provisions of the Adults with Incapacity (Scotland) Act 2000 **("the 2000 Act")**. The legal procedures do not, however, cover deprivation of liberty specifically and leave uncertainty for those who work with adults with incapacity.

The decision of the Supreme Court in the case of *P v Cheshire West and Chester Council; P and Q v Surrey County Council* (March 2014) is also of considerable relevance. The Supreme Court developed an "acid test" for determination that deprivation of liberty is taking place – namely that a person who lacks capacity to consent to their own living arrangements is subject to the complete and effective control of those who care for them and is not "free to leave." The result is that Article 5 is engaged, in England and Wales, in any situation where a person living in a care setting for which the State is ultimately responsible lacks capacity to consent to their own living arrangements and is in a situation where the elements of the acid test are present. This certainly applies to all care homes (albeit not to any resident who can and does consent) – with the attendant resources implications flowing from that. Whilst strictly speaking the decision is not binding in Scotland, it is of very high authority. The judgement has understandably given rise to a degree of uncertainty and concern among local authority staff in Scotland.

A case involving challenge to residential care arrangements in Scotland on Article 5 ECHR grounds is due to be heard in the Court of Session in October 2014. The decision may address some of the concerns and uncertainty but is, of course, limited to the facts of the case.

The project on adults with incapacity was included in the Scottish Law Commission's (**"SLC"**) Eighth Programme of Law Reform, following a suggestion

by various bodies in response to consultation on that Programme.

- **Objective**

  The recommendations in the Report and the provisions of the draft Bill address the need for legal safeguards if measures of detention are applied to adults who lack capacity in this respect, but with the minimum level of process and intervention required to do so.

  The draft Bill provides for legal processes tailored to two areas. The first area is restriction of liberty of adults with incapacity who are receiving medical treatment or undergoing assessment in hospital.

  The second area is restriction of liberty in certain residential care settings which are intended to be a person's home. The draft Bill deals with care homes and accommodation for adults which is arranged by adult placement services (defined in the Public Services Reform (Scotland) Act 2010). This "community process" applies to adults who lack the capacity to consent to their own living arrangements. The process does not cover authorisation of the decision about where a person should live.

  "Deprivation of liberty" is not defined in the draft Bill. The key consideration is that it is a question of degree when a restriction of liberty becomes a deprivation. The community process seeks to cover those whose liberty is restricted to a significant extent as a result of a combination of at least two restrictive measures, which in combination the European Court of Human Rights in Strasbourg would be likely to regard as amounting to a deprivation of liberty.

  It is intended that the legal processes are used only insofar as is necessary to comply with the European Convention on Human Rights, and where the process is engaged that it involves only the minimum possible level of intervention.

  In addition to these two processes there is also to be provision for application to the sheriff for the cessation of unlawful detention in care homes or in accommodation arranged by adult placement services.

- **Rationale for Government intervention**

  The proposals advance the Scottish Government's national objective relating to the living of longer, healthier lives. There would be greater scrutiny of measures that are put in place for those who lack capacity in the relevant respects. This would be of benefit to the residents of care facilities and those who require restriction of liberty in connection with medical treatment. This could contribute to an overall improvement in quality of life for adults in these situations.

Consultation

- **Within Government**

  The SLC had meetings and contact with Scottish Government officials at various stages of the project. The Scottish Government has been kept apprised of the progress of the project, in particular of the broad outline of the recommended policy approach after the publication of the Discussion Paper and later on of the

draft Bill provisions and Report.

- **Public Consultation**

  Consultation was carried out in accordance with the SLC's established practice in conducting law reform projects.

  In July 2012 the SLC published a Discussion Paper on Adults with Incapacity (**"the Discussion Paper"**). The Discussion Paper was circulated to individuals and bodies which the SLC had identified as being likely to have an interest in the project. It was also published on the SLC's website and was therefore freely available to the general public online. It sought the views of interested stakeholders on 27 substantive policy questions. The consultation was open for 12 weeks. A total of 31 responses to the Discussion Paper were received and most of them were lengthy.

  Those submitting responses included People First (Scotland), Scottish Consortium for Learning Disability, academics, representatives of local authority social work departments (mainly in the capacity of mental health officers), carers' organisations, advocacy organisations, a psychiatric nurse, members of the Royal College of Psychiatrists (which sent two separate responses. One was from the Faculty of Old Age Psychiatry and the other was a joint response from the Faculty of Psychiatry of Intellectual Disabilities and the Faculty of Child and Adolescent Mental Health), the Equality and Human Rights Commission, the Mental Welfare Commission for Scotland, the Mental Health Tribunal for Scotland, the Senators of the College of Justice and the Scottish Court Service and the Office of the Public Guardian.

  The responses to the questions posed in the Discussion Paper were collated and a summary of the main arguments raised in each of the responses was prepared. It is notable that there was a very mixed response to most questions, with both ends of a spectrum of opinion often represented. For example in relation to the definition of deprivation of liberty most consultees agreed that there was a lack of clarity as to the meaning of deprivation of liberty. Some had concerns about defining it; others offered thoughts on what a definition should include; a majority thought that guidance had a role to play and a number of consultees thought that legislation should be used for greater specification. But some argued that a definition should not or could not be achieved in legislation.

- **Business/Other**

  Prior to publication of the Discussion Paper the SLC set up an advisory group. The group comprised eight members, a number from legal and social work backgrounds, together with representatives of Alzheimer Scotland, ENABLE Scotland and the Dementia Services Development Centre at Stirling University. The SLC team held meetings with the advisory group at various stages of the project, both before and after publication of the Discussion Paper. Members of the advisory group were also given the opportunity to comment on material by correspondence at various points in the project. In particular, members of the advisory group received sight of the draft Discussion Paper and draft Bill in advance of publication of both documents, with an invitation to submit any points they wished to raise.

  In addition to the public consultation, and as part of the process of finalising

certain aspects of our policy, we have held small group discussion meetings with people with expertise in a number of fields. Those fields are psychiatry (old age and learning disability) and medicine of the elderly, social work, local authority management, care home management and advocacy, and others working with and on behalf of those affected by learning disability. Organisations represented in the groups included People First (Scotland), CrossReach, Scottish Independent Advocacy Alliance and the Scottish Consortium for Learning Disability. The purpose of the small group meetings was to initiate discussion and feedback on the proposed new processes. In advance of the meetings participants were provided with a note outlining how the relevant proposed new processes were envisaged to operate, together with a copy of the draft Bill.

Options

Option 1: do nothing

Option 2: pass and implement the Bill

Option 3: as Option 2 but extend the new community process to all those who are subject to only one measure of restriction of liberty.

- **Sectors and groups affected**

The implementation of options 2 and 3 could have resource implications for all of the following people and sectors: Medical practitioners, hospitals, social workers (including, but not exclusively, mental health officers), local authority social work departments, care homes/care home managers, people exercising powers of attorney and guardianship powers, sheriffs/sheriff courts.

The same people and sectors may be affected by option 1 if the lack of a firm legal basis for use of any combination of measures of restriction which would be likely to be regarded by Strasbourg as amounting to a deprivation of liberty, was to be challenged in court.

- **Benefits**

There are no directly calculable benefits in monetary terms. However the following comments may be made:

Option 1 – We cannot see a benefit to option 1. The law in Scotland on deprivation of liberty would remain uncertain and in certain situations open to challenge.

Option 2 – This would ensure a legal basis for the use on a regular basis of any combination of measures of restriction giving rise to a significant restriction of liberty, in care homes and adult placements. It would also provide a legal basis for use of measures to prevent a person going out of a hospital, while in hospital in connection with provision of medical treatment or assessment. Allied to this would be the right to challenge any authorisation of significant restriction of liberty, exercisable by the person concerned or anyone interested in the welfare of the person concerned bringing proceedings at first instance in the Sheriff Court. An equivalent right would be exercisable by the patient or any person claiming an interest in the personal welfare of the patient, where measures are in place to prevent a patient going out of a hospital. It is designed to close the *Bournewood* gap with the minimum level of process and intervention required.

Option 3 – This would mean that the community process would be widely applied. There would be no scope for challenge of the reach of the process, for example in respect of the exclusion from the scheme of those who are subject only to the measure of living somewhere with a locked door, as there could be with option 2.

- **Costs**

Option 1

Pursuing option 1 would mean the continued absence of a firm legal basis for the authorisation of deprivation of liberty. This could be subject to challenge, with potentially significant costs attached to that. Irrespective of that working round the issue may have a cost attached to it, too. For example local authority employees or hospital staff trying to establish what amounts to a deprivation of liberty and what legal steps they should take will take time and cost will be incurred.

Option 2

Costs are attached to the processes under the proposed new provisions to be introduced in the 2000 Act:

Measures to prevent an adult patient from going out of a hospital

The cost would include the time of a medical practitioner in carrying out the assessment as to whether an adult lacks capacity in relation to decisions as to whether or not to stay in hospital and, if so, to certify that and decide what restrictions should be implemented to ensure that the adult stays in the hospital. To keep cost to a minimum it is anticipated that this certificate will be in a similar format as the certificate for the process which is required for medical treatment of an adult who lacks capacity to make decisions in relation to that treatment (section 47 of the 2000 Act). We estimate that between 20 and 45 minutes would be needed per person per assessment on average. The cost of a medical practitioner per hour may vary depending on their experience.

Added to this would have to be the cost of time of a medical practitioner in keeping the assessment of the adult under review and, where appropriate, revoking the certificate of incapacity.

We would envisage that the types of costs involved would be the same as between NHS and independent hospitals.

It is not easy to predict with certainty how many patients in hospitals would have such a certificate of incapacity. As at the end of March 2014 there were 16,484 staffed beds in acute specialities across all the NHS hospitals in Scotland but there is no specific data as to how many patients will have been incapable of deciding whether or not stay in hospital.

The vast majority of adults affected would be those suffering from dementia. According to a report published by the Mental Welfare Commission in 2010 focussing on visits to people with dementia in acute hospital wards, it was at that time estimated that people over 65 who had dementia were occupying 25% of beds in acute wards in general hospitals. Taking the figure of 16,484 staffed beds, that would mean that on the day of measurement at least 4,121 people

over 65 with dementia would have been in acute wards in general hospitals in Scotland. However, because they are physically frail, not every person with dementia will have been in need of measures to keep them in hospital so the actual number would be **fewer than 4,121 adults**.

The number of adults in independent hospitals falling within the process would be considerably fewer. There are considerably fewer in-patient beds in independent hospitals than in NHS hospitals. In 2009 there were 313 beds for acute patients across nine independent hospitals in Scotland (according to the Scottish Independent Hospital Association's submission to the Scottish Parliament in relation to the Public Services Reform (Scotland) Bill). Taking the same percentage as in NHS hospitals of 25% that would mean that **fewer than 78 adults** in independent hospitals would have been caught by the process under option 2.

As the measures preventing an adult patient from going out of hospital can be challenged in court, the new process might also incur costs in relation to court time. This could include the time of the appropriate sheriff principal and in some cases of judges in the Court of Session. There would also be costs of healthcare providers in defending their position in the proceedings. However, we think that court proceedings in these circumstances are unlikely, given the short duration of most such hospital admissions and the clear need for physical healthcare.

Application to the sheriff for cessation of unlawful detention in care setting

£95 is the average cost of a summary application to the sheriff court according to the Scottish Court Service (Source: BRIA of the Housing (Scotland) Bill 2013). To this would have to be added the time and cost of managers in care settings in defending actions.

There is no easy way to predict how many applications to the sheriff are likely to be brought per year. A possible analogy to draw is with section 291 of the Mental Health (Care and Treatment) (Scotland) Act 2003 (application to the Mental Health Tribunal for unlawful detention), which on average generated fewer than four applications a year: between 2006 and 2013 a total of 29 applications were made to the Mental Health Tribunal under section 291. The Tribunal refused the order in 15 cases and made an order in 14. We think that there is a higher chance of people going to the Mental Health Tribunal to scrutinise compulsory mental health treatment than there would be of people in a care setting going to the sheriff court.

Community process

In the community process, there would be a statement of significant restriction, setting out what measures had been authorised and the reasons for that. The cost in detail would involve:

The cost of time of a medical practitioner in carrying out the initial assessment and, where appropriate, issuing a certificate to the effect that the adult is incapable of making decisions as to restriction of liberty. Assuming that the cost per hour of a General Practitioner for general medical services is around £120 and that an assessment may on average take between 30 and 50 minutes, this would mean that the cost per person per assessment may be between £60 and £100.

The cost of time of a manager of a care home (or adult placement service manager) in preparing a draft statement of significant restriction and seeking the views of the mental health officer and medical practitioner on the draft statement of significant restriction and where necessary resolving differences of opinion. Where there is no such manager, the task would fall instead to the main social worker involved in the case of the person lacking capacity. We estimate that the time required to prepare a draft statement would not be less than 60 minutes but could be longer, if differences of opinion arose.

There would also be the cost of time of mental health officers and medical practitioners in considering and preparing reports on draft statements of significant restriction. We estimate that they would each take between 30 and 60 minutes per person per assessment.

There would be court costs a) if a dispute between professionals could not otherwise be resolved or b) where authorisation by a sheriff is needed because no attorney or guardian had been appointed. There would also be court costs and cost of parties where there is to be an appeal against a decision to authorise a significant restriction of liberty. This may include costs of the time of the relevant sheriff principal and ultimately the Court of Session. As we have already said, the Scottish Court Service has indicated that the average cost per summary application is £95.00, according to the BRIA for the Housing (Scotland) Bill 2013.

It is not easy to estimate how many people would fall under the community process but in an attempt to establish likely numbers we have looked at data in the most relevant areas: adults with a learning disability and adults suffering from dementia. We have not been able to find reliable figures for adults with acquired brain injury.

Learning disability

According to the 2013 statistics released by the Scottish Consortium for Learning Disability there were 26,236 adults with learning disabilities known to local authorities living in Scotland in 2013. Only a proportion of these will be living in a care setting. As at March 2013 there were, according to the Care Home Census for 2013, 1,588 people with learning disabilities living as long-stay residents in care homes. We estimate that approximately one quarter of those, which would be 397 people, are likely to require to be subject to measures amounting to a significant restriction of liberty at any one time.

Dementia

As at 31 March 2013 there were, according to the Care Home Census 2013, 911 care homes for older people (aged 65 and over) providing 38,508 places to 32,888 residents, of whom 31,752 (97%) were long-stay residents. 52% of those long-stay residents (ie approximately 15,876) had a formal diagnosis of dementia. We estimate that approximately a quarter of those 15,876 people would be likely to require to be subject to a significant restriction of liberty, which would be 3,969 people. We have not taken into account the people who were identified as having dementia but had not been formally diagnosed as such (approximately 8% of long stay residents, which would be 2,536 people), because we assume that where measures amounting to significant restriction are applied, a formal diagnosis would take place.

The figures above do not take into account that people with learning disability can

develop dementia.

Option 3

Community process

The main difference between this option and option 2 is that option 3 would have the effect that the community process would capture every person lacking capacity to consent to their living arrangements who is living in a residential care home or in accommodation arranged by an adult placement service in which they are subject to at least one measure of restriction of liberty. The typical example might be the locked door for which residents do not have a key or do not know the keypad code.

If this option is pursued the community process is likely to cover the vast majority of long-stay residents in care homes who are aged 65 and over and/or have a learning disability. According to the Care Home Census 2013, there were 32,888 residents aged 65 or over in care homes in Scotland and 1,588 long stay residents in care homes for adults with learning disabilities.

The types of costs which would have to be factored in would remain the same as under option 2. However the total costs would be considerably higher, given the greater number of people involved.

Unlawful detention in care settings

For option 3 it is not clear to what extent the figure for applications under section 291 of the Mental Health (Care and Treatment) (Scotland) Act 2003 provides a useful guide. It seems figures under the new process could be much higher given that the provision could potentially be relied upon by the much greater number of people who would/should be subject to an authorisation under the community process. One of the grounds for application to the sheriff would be that a significant restriction of liberty had not been properly authorised in accordance with the requirements of the 2000 Act (as amended by the provisions of the draft Bill).

The types of costs which would have to be factored in would remain the same as under option 2.

- **Scottish Firms Impact Test**

Care home providers

As at 2013 the majority of care homes for adults in Scotland were run by the private sector (a total of 715) and 367 were run by the voluntary sector; 199 were run by local authorities/Health Boards. As regards independent providers of care home services, we estimate that the main costs would be in relation to the time of managers in arranging the appropriate initial assessment (although that would be part of the already existing requirement to assess the needs of a resident with a view to including that in the person's care plan) and thereafter going through the processes involved in preparing and canvassing views on a draft statement of significant restriction. The number of hours involved in this is likely to be variable, depending on the particular facts, circumstances and complexities of individual cases. The extent to which significant restriction of liberty is necessary

would, inevitably, vary according to the typical care needs of residents cared for in a particular setting.

Costs to independent care home services could be incurred where proceedings were raised before the sheriff on the grounds of failure to comply with the requirements of the community process. However, we estimate that the threat of this is likely to be sufficient to ensure that (over time) the procedure would be properly followed in the vast majority of cases. On that basis we estimate that any such costs would be minimal.

Independent hospitals

The types of costs potentially incurred by independent hospitals would be as set out above. We would estimate that they would be of a minimal level given the relatively low numbers of patients in question (see above).

- **Competition Assessment**

Using the Competition & Markets Authority Competition Filter questions we have concluded that the proposals will neither directly nor indirectly limit the number or range of suppliers or reduce suppliers' incentives to compete vigorously. Nor will they limit the ability of suppliers to compete. We assume that the market for care is defined by what type of care is required as the different types of care are not regarded as interchangeable or substitutable (see European Commission Notice on the definition of the relevant market - *OJ C 372, 09.12.1997, p 5–13*). For example a person with severe learning difficulty would look for a facility to cater for their specific needs and as a result would not regard a care home specialising in dementia care as suitable. As regards the community process, the extent to which individual care homes would require to seek authorisation of a significant restriction of liberty would, as indicated above, depend upon the type of care which was mainly being provided. The costs involved, mainly in the expending of time by the manager of the facility, may necessitate an increase in the number of staff to be recruited or otherwise an increase in the overall fees charged for care. However, this would affect all care homes which provided the types of care typically needed for adults who require to be restricted in their liberty.

For a proposal to present difficulty from the point of view of competition policy any effect on trade must be appreciable (see Commission Notice on the effect on trade - *OJ C 101, 27.04.2004, p. 81–96*). We would not expect the proposals to have any significant impact on different independent hospitals. This is based on our thinking set out above in relation to the minimal costs likely to be associated with the assessment of capacity.

- **Test run of business forms**

The draft Bill prescribes no business forms. There is therefore no need to carry out a test run.

- **Legal Aid Impact Test**

The draft Bill creates a number of opportunities for an adult lacking capacity, or any person with an interest in the personal welfare of the adult, to bring proceedings before the sheriff in the first instance. These are predominantly proceedings to challenge the exercise of powers, though not exclusively so.

There is, for example, the proposed new application to the sheriff for cessation of unlawful detention of the adult. And the authorisation of implementations of significant restrictions of liberty by the sheriff where there is no attorney or guardian to do so. We would envisage that a number of people bringing proceedings under these provisions might be eligible for civil legal aid. The Legal Aid Board has confirmed that they have no comments on this at this stage.

- **Enforcement, sanctions and monitoring**

SCSWIS (Social Care and Social Work Improvement Scotland) has responsibility for inspection of the vast majority of settings in which the community process would apply. Inspections could be carried out with reference to any statements of significant restriction in place in relation to residents.

The Mental Welfare Commission would have a role in relation to receiving and retaining notification of any authorisation of a significant restriction of liberty, together with any renewal of authorisation. They would receive and retain a copy of each statement of significant restriction on the basis of which authorisation, or renewal of authorisation, was given. In a similar vein, inspections of hospitals would be undertaken by Healthcare Improvement Scotland. Inspectors would be able to look at certificates of incapacity that were in place at the time of the inspection.

The draft Bill does not impose any sanctions.

- **Implementation and delivery plan**

We would envisage that the provisions would be part of a Scottish Government Bill dealing with adults with incapacity. In that event the provisions would be commenced as provided for in the draft Bill.

- **Post-implementation review**

In accordance with the Law Commissions Act 1965, section 3(1), the SLC has a duty to "keep under review" the laws with which it is concerned. We expect that the Scottish Ministers would review the legislation within the first ten years after commencement.

- **Summary and recommendation**

Option 1 is dismissed because it would maintain the uncertainty of the current law which is unsatisfactory.

The difference between Option 2 and 3 lies in the number of adults in relation to whom a process of authorisation would have to be carried out.

Option 2 is being recommended. This ensures that there is a proper legal basis for any use of measures amounting to a deprivation of liberty, be that in connection with the administration of medical treatment or assessment in hospital or with regard to living in a residential care home or in accommodation arranged by an adult placement service. There would also be a means of applying for cessation of unlawful detention.

Option 3 is undesirable because it may lead to unwarranted bureaucracy, time

and expense of a system that is so widely applicable as to catch every person who is subject to any measure of restriction of liberty, even if that goes no further than living in a care setting with a locked door for which they do not have a key or code. This would have implications not only in resource terms but, equally importantly, would be likely to represent an unwelcome intrusion in the lives of those receiving care and their families. As an example may serve the estimated ten-fold increase in workload of local councils in England and Wales to address the change of the law by the Supreme Court judgement mentioned above according to a survey by the Association of Directors of Adult Social Services (mentioned in the Independent on 12 June 2014).

- **Summary costs and benefits table**

	Number of people	Cost per person
Option 2:		
Community process:		30 to 50 minutes of medical practitioner's time @ £120 per hour plus 60+ minutes of care home manager, plus time of Mental Health Officer (30 to 60 minutes) and medical practitioner (30 – 60 minutes).
Learning disability	397	
Dementia	3,969	
Community process sum	4,366	
Hospital	4,121+78 = 4,199	20-45 minutes of medical practitioner's time + review + legal challenge (if applicable)
Sum for Option 2	**8,565 adults**	
Option 3:		
Community process	32,888 + 1,588= 34,476	Ditto
Hospital	4,199	Ditto
Sum for Option 3	**38,675 adults**	**£**

Declaration and publication

I have read the impact assessment and I am satisfied that (a) it represents a fair and reasonable view of the expected costs, benefits and impact of the policy, and (b) that the benefits justify the costs I am satisfied that business impact has been assessed with the support of businesses in Scotland.

Signed: Paul B Cullen

Lord Pentland, Chairman, Scottish Law Commission

Date: 26/4/14