The Law Commission

Consultation Paper No. 130

Mentally Incapacitated and Other Vulnerable Adults

Public Law Protection

HMSO

The Law Commission was set up by section 1 of the Law Commissions Act 1965 for the purpose of promoting the reform of the law.

The Law Commissioners are:

The Honourable Mr Justice Brooke, *Chairman*
Mr Trevor M. Aldridge, Q.C.
Mr Jack Beatson
Mr Richard Buxton, Q.C.
Professor Brenda Hoggett, Q.C.

The Secretary of the Law Commission is Mr Michael Collon and its offices are at Conquest House, 37-38 John Street, Theobalds Road, London WC1N 2BQ.

This consultation paper, completed on 5 April 1993, is circulated for comment and criticism only and does not represent the final views of the Law Commission.

The Law Commission would be grateful for comments before 31 July 1993. All correspondence should be addressed to:

Mr N. Lambe
Law Commission
Conquest House
37-38 John Street
Theobalds Road
London WC1N 2BQ

Tel: 071-411 1267
Fax: 071-411 1297

It may be helpful for the Law Commission, either in discussion with others concerned or in any subsequent recommendations, to be able to refer to and attribute comments submitted in response to this consultation paper. Whilst any request to treat all, or part, of a response in confidence will, of course, be respected, if no such request is made the Law Commission will assume that the response is not intended to be confidential.

The Law Commission

Consultation Paper No. 130

Mentally Incapacitated and Other Vulnerable Adults

Public Law Protection

LONDON: HMSO

ISBN 0 11 730213 9

THE LAW COMMISSION

CONSULTATION PAPER NO. 130

MENTALLY INCAPACITATED AND OTHER VULNERABLE ADULTS

PUBLIC LAW PROTECTION

TABLE OF CONTENTS

PART I

INTRODUCTION

1.1 This is the third paper in a second round of consultation on this subject. In April 1991 we published a preliminary Consultation Paper, Mentally Incapacitated Adults and Decision-Making: An Overview (referred to here as "the overview paper").[1] Its object was to assess the extent of the need for reform and the most practicable way forward in a difficult and diffuse area. To date over 120 responses have been received. We have also held valuable meetings with several groups of interested organisations and individuals. In September 1991 the Scottish Law Commission also published a Discussion Paper on Mentally Disabled Adults.[2] The main criticisms of the present law in Scotland reflect concerns very similar to those identified in England and Wales.

1.2 The great majority of respondents to our overview paper supported reform, but no clear consensus emerged on the form that this should take. Many respondents favoured an overall solution, while others feared that this would take too long, might not be implemented and would not allow specific problems to be explored in sufficient depth. From the responses it became clear that further detailed work and consultation on specific proposals were required. We have now divided the project into a number of discrete but interlocking topics. We aim to take these forward in a consistent manner, resulting, we hope, in an integrated solution. This paper forms part of that process. We have already published further consultation papers dealing with the "private law"[3] and the law relating to medical treatment.[4]

---

1 Mentally Incapacitated Adults and Decision-Making: An Overview (1991), Consultation Paper No. 119.

2 Mentally Disabled Adults: Legal Arrangements for Managing their Welfare and Finances (1991), Discussion Paper No. 94.

3 Mentally Incapacitated Adults and Decision-Making: A New Jurisdiction (1993), Consultation Paper No. 128.

4 Mentally Incapacitated Adults and Decision-Making: Medical Treatment and Research (1993), Consultation Paper No. 129.

1.3 In the first of these papers, we set out provisional proposals for the establishment of a new integrated "private law" jurisdiction, in which decisions relating both to the personal care and to the financial affairs of incapacitated people could be made. In the paper on medical treatment and research we explored the idea of the legal machinery whereby substitute decisions about medical treatment could be authorised at an appropriate level. We also suggested the creation of a jurisdiction to decide on the scope and validity of decisions concerning medical treatment made by the incapacitated person before the onset of incapacity. In this paper we address the role of the public law in relation to incapacitated people. We also consider whether public authorities should have certain powers in relation to people who are especially vulnerable even though they may not be legally incapacitated.

Public law

1.4 By the "public law" we mean the powers of public authorities, principally local social services rather than district health authorities. It is no part of this project, however, to review those authorities' basic powers to provide or arrange health or social services for people who need them; nor are we concerned with the remedies or redress which might be available to individuals who wish to complain about the quantity or quality of the services provided or arranged for them. There is an existing body of law on this subject, which has recently undergone radical changes following the National Health Service and Community Care Act 1990. Our project has to be seen against the background of that existing body of law but, as we said in the overview paper,[5] the level of health, educational and social services which ought to be provided for the people with whom we are concerned is outside the scope of a law reform exercise such as this.

1.5 As we also said in the overview paper,[6] our concern is with the legal machinery which may be necessary to identify mentally incapacitated people, to give them any necessary help in taking those decisions which they are unable to take for themselves, and to protect them from abuse, exploitation or neglect. There is already some machinery in public law for

---

5 Consultation Paper No. 119, para. 1.15.

6 *Ibid.*

these purposes, principally in section 47 of the National Assistance Act 1948,[7] in sections 135 and 136 of the Mental Health Act 1983,[8] and in the guardianship provisions of the 1983 Act.[9] For a variety of reasons, however, that machinery is inadequate or ineffective and our aim is to improve it.

Vulnerable people

1.6 For this purpose, we think it essential to go beyond the narrowly defined group of mentally incapacitated clients with whom this project is principally concerned. Incapacitated people may need other people to take decisions for them which they are unable to take for themselves. They may also be especially vulnerable to abuse or neglect from which they require official protection. However, there are other people who are not incapable of taking their own decisions, but are also especially vulnerable to abuse or neglect from which they are unable to protect themselves. Some machinery is needed to protect them and the existing procedures outlined in this review already do so to some extent.[10] However, thay are widely believed to be unsatisfactory for this purpose.

Resource implications of our proposals

1.7 We do not see our proposals as having major resource implications for local authorities. As will emerge later in this paper,' our provisional proposals will not result in a significant extension of their existing responsibilities of this nature. When seen in the context of their principal powers and duties to assess, provide and arrange community care services for very large numbers of clients, the question of invoking potentially compulsory powers of intervention arises very rarely. Indeed, to the extent that professional time and energy has at present to be expended in finding alternative solutions, because of the deficiencies of the

---

7 See paras. 2.10-2.11 below.

8 See paras. 2.12-2.14 below.

9 See para. 2.15 and Part IV below.

10 See paras. 2.9 *et seq* below, and in particular paras. 2.10-2.11 which examine s.47 of the National Assistance Act 1948.

present law, we believe that our proposals could result, not only in better protection for their clients, but also in a more efficient use of the authorities' resources. However, we would welcome comments on this.

Abuse of elderly or disabled people

1.8 Abuse of the elderly has been a concern since the mid 70s[11] but it is only recently[12] that it has been looked at as a social problem and in a systematic way.[13] The existence of abuse in institutions has long been widely suspected if not always reported. However, professionals working with elderly and other vulnerable adults are increasingly becoming aware of abuse taking place within the homes of abused adults. Such abuse may come to light only at a late stage when professionals have become involved with the client for other reasons.[14]

1.9 The extent of the abuse of the elderly and other groups in the UK is still largely unknown[15] although incidence surveys into the numbers affected, the types of abuse and the likely profile of the perpetrators are starting to be carried out. For example, a survey by Bennett and Ogg revealed 5% of those aged over 60 reported that they had been abused.[16] Abuse was defined to include, *inter alia*, being shouted at, pushed, slapped and roughly handled and having money taken without consent.[17]

---

[11] See e.g. A.A. Baker, "Granny Battering" (1975), 5 (8) Modern Geriatrics 20 and G.R. Burston, "Granny-battering" (1975), 3 B.M.J. 592.

[12] In 1990 the Age Concern Institute of Gerontology was commissioned by the Department of Health to undertake an exploratory study, C. McCreadie, *Elder Abuse: an exploratory study* (1991).

[13] SSI London Region Survey, *Confronting Elder Abuse* (1992), p.1.

[14] In the SSI study cited above, 46 of the 64 cases were already known to the Social Services Departments.

[15] The lack of information on the extent of violence to the elderly led the Council of Europe to commission reports from member states detailing the incidence of abuse and, in particular, legal responses to abuse. See Council of Europe, *Violence Against Elderly People* (1992).

[16] J. Ogg and G. Bennett, *National Survey of Elder Abuse* (1992).

[17] *Ibid.*, p.4.

1.10 One of the difficulties in referring to the studies is that there is no standard definition of abuse.[18] Some studies include financial abuse[19] while others limit investigation to physical interference such as restraint.[20] Nevertheless there seems to be a consensus that elder abuse is a very real problem the causes of which cannot be attributed to a single theory.

1.11 The level of abuse of those with learning disabilities is even less well documented than abuse of the elderly and focuses almost exclusively on sexual abuse. In one survey concerned with abuse of adults with mental handicap the rate of abuse reported by consultants in the Psychiatry of Mental Handicap was calculated to be 4 to 5% although the consultants felt that there was likely to be a much higher hidden prevalence.[21]

1.12 As with child abuse there appears to be some reluctance to admit to the scale of abuse of the elderly and other vulnerable adults. One reason for this may be a recognition of the demands made upon the families and carers of elderly and disabled people and the pressures which may lead them to abuse the people they are looking after. In any event the degree of suffering and distress endured would justify a critical examination of the legal powers to offer them protection. Many respondents to our overview paper urged the need for reform of the existing public law powers to deal with potential crisis situations. One of these[22] expressed concern about widespread professional ignorance relating to emergency procedures and their ineffectiveness in practice.

Guardianship and the Mental Health Act

1.13 Our respondents also urged reform of the longer term procedures providing for looking after the interests of incapacitated people. This raises two questions. First, how far

---

18 A frequently quoted definition is that of Mervyn Eastman: "the systematic maltreatment, physical, emotional or financial of an elderly person...this may take the form of physical assault, threatening behaviour, neglect and abandonment or sexual assault." M. Eastman, *Old Age Abuse* (1984), p.23.

19 J. Ogg and G. Bennett, *op. cit.*

20 A.C. Homer and C. Gilleard, "Abuse of elderly people by their carers" (1990), 301 B.M.J. 1359.

21 L.B. Cooke, "Abuse of mentally handicapped adults" (1990) 14 Psychiatric Bulletin 608.

22 National Development Team for the Mentally Handicapped.

can and should the guardianship procedure in the Mental Health Act 1983, which is essentially a public law power, be extended or adapted for this purpose? Secondly, what should be the relationship between that procedure and any new system for making decisions about personal care and welfare, including the appointment of personal attorneys and managers, as proposed in our private law paper? It may be preferable to distinguish between substitute decision-making on behalf of incapacitated people and the kind of supervision or control in the community which is needed by some mentally disordered people who might otherwise have to be in hospital. We are not concerned in this project with recent proposals for community supervision orders over certain patients discharged from hospital, or with the position of detained patients who have to be admitted to hospital under the 1983 Act.[23]

The aims of intervention

1.14 Compulsory intervention may be needed to deal with two distinct problems. The first is the refusal by the client of local authority help and support when without them he will no longer be able to live an independent life in the community. The second is where a carer or other person with whom the client is living refuses access to the client or refuses the provision of services to the client.[24] Intervention should not necessarily be seen in a negative light. If it prevents abuse or neglect, or otherwise improves the quality of life of the client, it will clearly have had a beneficial impact.

1.15 There is a difficult balance to be struck between maximising freedom of choice and autonomy and ensuring adequate protection for those who need it. Public intervention in the lives of children is based on the presumption that they are incapable of providing for themselves but with adults the contrary presumption applies. The policy aims set out in our overview paper were supported by many respondents and remain the basis of our approach:

---

[23] The Secretary of State for Health has recently announced a review of the Mental Health Act 1983, Written Answers, *Hansard* (HC), 13 January 1993, vol. 216, col. 731.

[24] The case of Beverley Lewis concerned this problem. Beverley Lewis was a profoundly mentally and physically handicapped young woman who died at home in 1989 of lobar pneumonia due to emaciation and cerebral disability. Her mother, with whom she lived, suffered from schizophrenia and had obstructed the attempts of the local health and social services authorities to see Beverley and monitor her condition.

(i) that people are enabled and encouraged to take for themselves those decisions which they are able to take;

(ii) that where it is necessary in their own interests or for the protection of others that someone else should take decisions on their behalf, the intervention should be as limited as possible and concerned to achieve what the person himself would have wanted; and

(iii) that proper safeguards be provided against exploitation, neglect, and physical, sexual or psychological abuse.[25]

1.16 In relation to incapacitated people, these aims can justify both short term intervention to protect them against abuse or neglect and longer term intervention to ensure that sensible decisions are taken on their behalf. The existing provisions of the Mental Health Act provide for just this short and long term intervention in respect of the mentally disordered and the proposals in this paper are not intended to alter significantly the law relating to the mentally disordered. In relation to people who are simply vulnerable, however, these principles justify some short term intervention to protect them from abuse or neglect, but only on the assumption that the problem stems from their carers and that they themselves would welcome the authorities' help. The authorities may not know whether a person is incapacitated or only vulnerable until they have gained access to him and made some inquiries. Once the position has become clear, however, our present view is that a person who is capable of making his own decisions has the right to decline the authorities' help and protection, even if this means that he is left in an environment which is harmful to him. If he is capable of making the choice, that is a choice he must be allowed to make. It follows that longer term decision-making powers will not be justified.

The arrangement of this paper

1.17 The rest of this paper is arranged as follows. In Part II we discuss the people who might be covered by reformed public law powers. It is necessary to set this discussion in the

---

[25] Consultation Paper No. 119, para. 4.27.

context of the existing powers and duties of local authorities to provide services for particular client groups. Although people covered by the Mental Health Act are termed "patients", this is a misleading term in relation to people living in the community and requiring no particular medical or psychiatric care. We therefore propose to use the term "client", which is generally used for the wider groups of people covered by local authority social services. We would, however, welcome any alternative suggestions to the term "patient". In Part III we examine the range of short term powers which local authorities might need in order to safeguard and promote the welfare of incapacitated or vulnerable people. In Part IV we discuss Mental Health Act guardianship and the possible extension of its role to meet the longer term needs of incapacitated and other mentally disordered people. We raise for discussion, however, whether Mental Health guardianship is at all appropriate for the mentally incapacitated people who are the main subject of this project. In Part V we consider the possible role of local authorities in the new "private law" jurisdiction for incapacitated people which we have already proposed. We have also included as an appendix to this paper a short summary of the proposals in respect of the judicial remedies and jurisdiction made in the three Consultation papers in this second round of consultation.

PART II

DEFINING THE CLIENT GROUP

Introduction

2.1 In the discussion which follows we proceed on the assumption that some compulsory powers should be available to public authorities.[1] There are existing powers, notably the provision for compulsory removal under the National Assistance Acts,[2] the power to enter and remove under the Mental Health Act 1983,[3] and guardianship under sections 7-11 of the 1983 Act. As we said in the overview paper,[4] these powers are rarely invoked, may be difficult to exercise[5] and still leave some people unprotected. The people covered are at once wider and narrower than the incapacitated. In considering the client groups who might be covered by any reformed system of powers, it is necessary first to set out the overall responsibilities of local social services authorities to provide community care services.

Community care

2.2 The Government White Paper, *"Caring For People, Community Care in the Next Decade and Beyond"*,[6] defined community care as "... providing the right level of intervention and support to enable people to achieve maximum independence and control over

---

1 Age Concern, *The Law and Vulnerable Elderly People* (1986), p.29, "If one starts from the premise that under no circumstances may an adult who is not totally incompetent have his or her individual liberty curtailed or infringed in any way, then any proposals to reform present, or to introduce new, forms of welfare legislation are non-starters."

2 National Assistance Act 1948, s.47 and the National Assistance (Amendment) Act 1951.

3 Mental Health Act 1983, s.135.

4 Consultation Paper No. 119, para. 1.9(iv).

5 An added difficulty is that under existing arrangements the responsibility for intervening to protect adults lies with several different public authorities. This point is discussed further at paras. 3.11-3.13 below.

6 Cm. 849 (1989).

their own lives".[7] The proposals of the 1989 White Paper were enacted in the National Health Service and Community Care Act 1990. The reforms introduced by the Act are intended to:

> "enable people to live as normal a life as possible in their own homes or in a homely environment in the local community;
>
> provide the right amount of care and support to help people achieve maximum possible independence and, by acquiring or reacquiring basic living skills, help them to achieve their full potential;
>
> give people a greater individual say in how they live their lives and the services they need to help them do so."[8]

2.3 The 1990 Act gives the local social services authority the primary responsibility for coordinating the assessment of community care needs. Where, however, during the course of an assessment it appears to the local authority that there may be need for the provision of health or housing services the local authority shall invite the relevant agencies to participate in the assessment. The cornerstones of community care are care management and assessment. Care management is the process of tailoring services to individual needs.[9] It consists of seven integrated stages only one of which is assessment.[10]

---

7 *Ibid.*, para. 2.2.

8 *Ibid.*, para. 1.8.

9 Department of Health, Social Services Inspectorate, *Care Management and Assessment: Summary of Practice Guidance* (1991), para. 7.

10 The seven stages of care management are: (i) publishing information about the services available; (ii) determining the level of assessment to be carried out; (iii) assessment of the needs of the client; (iv) planning the care package in light of the assessment of need for services and taking into account the available resources; (v) the implementation of the care plan; (vi) monitoring the delivery of the care package and (vii) at specified intervals reviewing the care plan to ensure that services remain relevant to needs and to evaluate services as part of the continuing quest for improvement. See Department of Health, Social Services Inspectorate, *Care Management and Assessment: Practitioners' Guide* (1991).

2.4 Section 47 of the 1990 Act, which came into force on 1 April 1993, requires the local social services authority to carry out an assessment of the needs of any person who appears to be in need of community care services.[11] Section 47(1) reads:

> " Where it appears to a local authority that any person for whom they may provide or arrange for the provision of community care services may be in need of any such services, the authority:
> (a) shall carry out an assessment of his needs for those services; and
> (b) having regard to the results of that assessment, shall then decide whether his needs call for the provision by them of any such services."

2.5 Assessment is geared towards the specific needs of the individual client and therefore there are different levels of assessment depending on the complexity of the presenting facts.[12] The Practice Guidance suggests six model levels of assessment. In addition there is a statutory requirement that all clients appearing to be disabled are assessed according to the conditions of the Disabled Persons (Services, Consultation and Representation) Act 1986, that is, such clients are to be offered a comprehensive assessment irrespective of the scale of need initially presented.

Community care's client group

2.6 The client group served by the 1990 Act is simply that for whom the local authority may provide or arrange to provide "community care services". These are defined by reference

---

[11] The Department of Health, Social Services Inspectorate, *Care Management and Assessment: Managers Guide* (1991) refers to the assessment being carried out by a "practitioner". This word does not appear in the legislation but the Guide suggests that the term includes social workers, hospital and community based doctors and nurses and housing officers.

[12] The factors determining the level of assessment include the complexity of the needs presented by the client and the need for inter-agency assessment as the services which may be required involve not only social service provision but also provision of health services.

to other legislation, under which the authority has at times a power to provide services and at other times is under a duty to do so.[13]

2.7 "Community care services" are defined in section 46(3) of the 1990 Act as services which a local authority may provide or arrange to be provided under:

(a) Part III of the National Assistance Act 1948: this deals both with the provision of accommodation for people aged 18 or over who need it because of "age, illness, disability or any other circumstances"[14] and with the provision of a wide range of welfare services for "disabled" people.[15] These are defined[16] as people who are blind, deaf or dumb, or who are substantially and permanently handicapped by illness, injury or congenital deformity, and people suffering from any kind of mental disorder within the meaning of the Mental Health Act 1983;[17]

(b) section 45 of the Health Services and Public Health Act 1968: this deals with arrangements for promoting the welfare of "old people";

(c) section 21 of and Schedule 8 to the National Health Service Act 1977: this deals with services (other than residential accommodation) for the prevention of "illness", the care of people suffering from illness, and the after-care of people who have been

---

13 In cases (a), (b) and (c), the existence of the power depends upon ministerial approval, which may be converted into a duty by ministerial direction. Approval and in some cases directions, were given in Department of Health Circulars LAC (93)10 and 19/71. It is unlikely, however, that any of these provisions would be construed as conferring an enforceable right to services upon any individual: see *Wyatt v. Hillingdon London Borough Council* (1978) 76 L.G.R. 727.

14 National Assistance Act 1948, s.21(1)(a), as amended by the Children Act 1989, s.108(5), Sched. 13, para. 11(1) and the National Health Service and Community Care Act 1990, s.42(1)(a).

15 *Ibid.*, s.29.

16 *Ibid.*, s.29 (1).

17 Under the Mental Health Act 1983, s.1(2), "mental disorder" means "mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind".

so suffering; "illness" includes any form of mental disorder within the meaning of the 1983 Act;[18] and

(d) section 117 of the Mental Health Act 1983: this deals with the provision of after-care services for patients who have been detained in hospital for treatment under the long term compulsory powers in the 1983 Act and who "cease to be detained and leave hospital".[19]

"Community care services" under the 1990 Act do not include the other services which local social services authorities may provide for "disabled" people[20] under the following provisions:

(e) sections 1 and 2 of the Chronically Sick and Disabled Persons Act 1970;

(f) section 3 of the Disabled Persons (Employment) Act 1958.

However, under sections 4, 8(1) and 9 of the Disabled Persons (Services, Consultation and Representation) Act 1986, local authorities already have the duty to assess a disabled person's need for services under the 1970 Act, if asked to do so by the client or a carer. Under the 1990 Act, if a person being assessed for community care services appears to be "disabled" then a decision as to the services he requires (under the 1970 Act) must be made, whether or not an assessment has been requested in accordance with the 1986 Act.[21] Once the person has been assessed as in need of services a care plan should be drawn up which should ensure, as far as possible, that service provision preserves or restores normal living, primarily by providing the services within the user's home including the provision of day and domiciliary

---

18 National Health Service Act 1977, s.21 and Sched. 8, para. 2, as amended by the National Health Service and Community Care Act 1990, s.66(1) Sched. 9, para. 18(14). Health authorities have a parallel duty to provide services for this purpose, in so far as these are considered appropriate as part of the health service: National Health Service Act 1977, s.3(2)(a).

19 Again, a parallel duty to provide such services is placed on the district health authority. See also *R. v. Ealing District Health Authority, ex parte Fox* [1993] 1 W.L.R. 373.

20 Defined as in para. 2.7(a) above.

21 National Health Service and Community Care Act 1990, s.47(2).

care, respite care, the provision of disability equipment and adaptions to the home if necessary.

2.8 It will be apparent that the client groups covered by community care services include everyone who needs them because of old age, illness or disability. Any one of these conditions may include mental disorder. It follows that incapacitated people are automatically within the client groups for whom community care services may (and in some cases must) be provided. In the vast majority of cases the provision of community care services will obviate the need for recourse to any protective or compulsory powers.[22] It is only where the appropriate services are refused or obstructed that such powers may be necessary. The question arises, however, of how far protective or compulsory powers should be available, not only for the benefit of incapacitated people but also for a wider group of vulnerable people. In considering this question, it is necessary to look at the people covered by the existing law.

Protective powers: the existing law

2.9 In this section we look at the people in relation to whom the existing compulsory powers under section 47 of the National Assistance Act 1948, sections 135 and 136 of the Mental Health Act 1983, and guardianship under sections 7 to 11 of the 1983 Act may be used. We then explore why the definitions of these client groups have proved to be inadequate in that they have not resulted in the protection of all those who might need it. Next we discuss whether these might be amended or extended in any reformed system of law.

---

[22] The *Summary of Practice Guidance*, para. 46: "In their organisational arrangements, care agencies have to balance the requirements of those with short and long term needs. Care management is a process that is appropriate to both sets of needs but it will have its greatest impact in the care of the individual with long term needs."

National Assistance Act 1948

2.10 Section 47 of the National Assistance Act 1948 provides that, on the certificate of a community physician,[23] a district local authority[24] may apply to a magistrates' court for an order authorising a person's removal to suitable premises, usually provided by the local social services authority.[25] The section applies to those who:

> "(a) are suffering from grave chronic disease or, being aged, infirm or physically incapacitated, are living in insanitary conditions; *and*
> (b) are unable to devote to themselves, and are not receiving from other persons, proper care and attention."

Removal must be necessary, either in the best interests of the person to be removed, or to prevent injury to the health of, or serious nuisance to, other people. There is no requirement that the person be mentally incapacitated or even suffering from mental disorder.[26] Strictly speaking, incapacity may well arise from a cause which is not a "grave chronic disease". Even if it is an infirmity, the conditions in the home may not be insanitary, although the incapacitated person is seriously at risk. The power is rarely used[27] as it is regarded as inflexible and stigmatising. The division of responsibility between the professionals and

---

23 Who is now employed by the health service and not by either the district or the social services authority.

24 In non-metropolitan districts, therefore, this will not be the same authority as the local social services authority.

25 Under the National Assistance (Amendment) Act 1951, there is an emergency procedure for use when it is necessary to remove the person without delay. The community physician may make the application himself and there are several procedural short cuts, including a power to apply ex parte.

26 It is estimated that up to 50% of people so removed are mentally disordered; many of the others will be old or disabled people who may be living in insanitary conditions or otherwise causing alarm to their neighbours; while not mentally incapacitated, they may well be on the borders of mental disorder within the very wide meaning of the 1983 Act.

27 The figure most widely quoted is that the power is used approximately 200 times a year. See J. A. Muir Gray, "The ethics of compulsory removal", in Lockwood (ed.) *Moral dilemmas in modern medicine* (1985).

authorities concerned with implementing it is also a source of confusion.[28] There is no consensus amongst those professionally involved with the elderly as to whether section 47 should be repealed or simply amended. Some argue that section 47 is to be preferred over similar powers in the Mental Health legislation as it does not involve labelling the client "mentally disordered".[29] Repeal is also resisted on the ground that this power can be invoked when other statutory provisions are unavailable, for example when the client is not mentally disordered. However, these objections could be addressed by creating a new power aimed at giving both incapacitated and vulnerable people the protection they need. At the same time it could identify the circumstances in which the client should be entitled to decline that help. Accordingly we provisionally propose that:

1. **Section 47 of the National Assistance Act 1948 and the National Assistance (Amendment) Act 1951 should be repealed and replaced by a new scheme giving clearer and more appropriate powers to local social services authorities to protect incapacitated, mentally disordered or vulnerable people.**

2.11 Section 47 may well be used to remove people from their home when the use of public health legislation coupled with the provision of support services would be more appropriate. Apart from powers to deal with statutory nuisances under the Environmental Protection Act 1990,[30] the local authority also has wide powers to deal with "filthy or verminous premises and verminous persons." Section 83(1) of the Public Health Act 1936 requires the local authority, if it is satisfied that any premises are in such a filthy or unwholesome state as to be prejudicial to health, to give notice to the owner of any premises requiring him to take such steps as may be specified to remedy the condition of the premises by cleansing and disinfecting them. Where fumigation of the premises is necessary, section 36 of the Public Health Act 1961 permits the local authority to require the owner to vacate the premises until

---

[28] The impetus normally comes from the community physician, a health service employee, but the accommodation will usually be provided by the social services authority.

[29] S. Greengross, "Protection or compulsion?", (1982) 6 Journal of the Royal Society of Health 240.

[30] Sections 79 to 82 and Sched. 3.

they may be safely reoccupied. However, no person shall be required to vacate any premises used for human habitation unless alternative accommodation has been provided free of charge.[31] There is also a power of entry into any premises, at all reasonable times, for the purpose of ascertaining whether there is, or has been, any contravention of the provisions of the Public Health Act 1936.[32]

Mental Health Act 1983

2.12 Section 135(1)[33] of the Mental Health Act 1983 enables an approved social worker to apply to a Justice of the Peace for a warrant authorising any constable to enter premises, by force if necessary, in order to remove to a place of safety[34] a person believed to be suffering from mental disorder where there is reasonable cause to suspect that he:

> "(a) has been, or is being, ill-treated, neglected or kept otherwise than under proper control..., or
> (b) being unable to care for himself, is living alone...."

Detention under this section may be for no more than 72 hours. It is likely that any mentally incapacitated person who is at risk of neglect or abuse would be covered by this provision, although it also covers a wider group of people who may be mentally disordered but not incapacitated. Experience has revealed that this power is of little help in practice, particularly for mentally incapacitated or vulnerable people who may need long term care. If this is found to be necessary other provisions of the Act have to be used, but admission to hospital for psychiatric treatment will rarely be appropriate and reception into guardianship may not even

---

31 Public Health Act 1961, s.36(2).

32 Public Health Act 1936, s.287(1).

33 Section 135(2) deals with powers of entry to " ... take a patient to any place, or to take into custody or to retake a patient who is liable under this Act ...." We are not considering the law in relation to those liable to be detained under the Mental Health Act 1983.

34 "Place of safety" means residential accommodation provided by a local social services authority under Part III of the National Assistance Act 1948, a hospital as defined by the 1983 Act, a police station, mental nursing home or residential home for mentally disordered persons, or any other suitable place the occupier of which is willing temporarily to receive the patient: 1983 Act, s.135(6).

be possible.[35] If after the warrant expires there is no appropriate protective procedure there may be no alternative but to allow the person back home.[36]

2.13 In addition to this power to enter and remove people from home, section 136 of the 1983 Act gives a constable power to remove from "a place to which the public have access" any person who appears to him to be suffering from mental disorder and to be in immediate need of care and control, if the constable thinks this necessary in the interests of that person or for the protection of other people. As with section 135, detention is for a period not exceeding 72 hours.

2.14 The purpose of removal under section 136 is to enable the person to be assessed by a doctor and an approved social worker and to make any necessary arrangements for his treatment or care.[37] Under neither section 136(1) nor section 135(1) is it possible to treat the person without his consent. The aim is to determine whether the person concerned requires treatment for mental disorder and if so whether other powers under the Mental Health Act 1983 should be used when informal arrangements cannot be made.

Mental Health Act guardianship

2.15 A person may be received into guardianship under the Mental Health Act 1983 if he is aged 16 or over and:

> "(a) he is suffering from mental disorder, being mental illness, severe mental impairment, psychopathic disorder or mental impairment and his mental disorder is of a nature or degree which warrants his reception into guardianship under this section; and

---

[35] See Part IV below.

[36] This was in fact what happened in the case of Beverley Lewis. At the early stages of her involvement with social services her social worker had invoked s.135 only to find Beverley discharged. As a result the social worker was reluctant to invoke the same power again. See para. 1.14, n. 24 above.

[37] 1983 Act, s. 136 (2); see also Mental Health Act *Code of Practice*, para. 10.2.

(b) it is necessary in the interests of the welfare of the patient or for the protection of other persons that the patient should be so received."[38]

As was pointed out in our overview paper,[39] these criteria may severely restrict the use of guardianship to provide long term protection and support for mentally incapacitated people living in the community. Unless the person concerned is mentally ill or psychopathic, he must be suffering from "mental impairment". The definitions now require that, in addition to significant or severe impairment of intelligence and social functioning, there must be "abnormally aggressive or seriously irresponsible conduct" on the part of the person concerned.[40] It was undoubtedly the intention of the 1983 Act to exclude mentally handicapped people from the provisions for long term admission to hospital for psychiatric treatment. However, their consequential exclusion from guardianship may not have been intended. Guardianship has been much criticised in recent years, partly because it seems inadequate to cater for the needs of the clients who are included, and partly because the clients for whom it might be adequate are now excluded. In 1985, only 89 people were received into guardianship under section 7 of the 1983 Act; however, in 1992, the provisional figure had risen to 223.[41]

2.16 From this it should be apparent that some more coherent framework for the protection of these people is necessary. Arguing for a more rational basis upon which to intervene is not to ignore the differences between the individuals concerned or the different reasons why intervention may be needed. The principle of the least restrictive option requires that consideration be given to the circumstances of each individual case in determining what should be done. Respondents to our overview paper[42] identified two client groups in respect of whom the existing powers of local authorities are inadequate. These are the mentally incapacitated and the vulnerable.

---

38 1983 Act, s.7(2).

39 Consultation Paper No. 119, para. 3.30.

40 1983 Act, s.1(2).

41 See Written Answer, *Hansard* (HC), 18 February 1993, vol. 219, col. 317.

42 Consultation Paper No. 119.

2.17 Both the National Assistance Acts and section 135 of the Mental Health Act, are expressly designed to enable the short-term removal of the person concerned from home to other accommodation. Anecdotal evidence suggests that a common use of guardianship is to specify that the patient reside in a local authority or other residential or nursing home. However, this may be contrary to the guidance contained in the *Code of Practice*, which states that:

> "guardianship should never be used solely for the purpose of transferring an unwilling person into residential care"[43]

Until recently, the system has tended to encourage the provision of care, and treatment if necessary, for incapacitated or vulnerable people in a residential if not a hospital setting. A major objective of the recent changes is to place much greater emphasis on enabling people to remain at home for as long as possible.[44] It is known that removing elderly people from their homes, especially against their wishes, is likely to lead to a swifter deterioration in their health. Legal powers may therefore have to be tailored more flexibly to enable a wider range of interventions both in the short and longer term.

Incapacitated people

2.18 There is clearly a need for the public authorities to be able to take action to protect incapacitated people who are believed to be at risk of neglect (including self-neglect) or abuse in their present homes. In our consultation paper on the "private law"[45] we formulated proposals for a new jurisdiction in which issues about the care as well as the finances of incapacitated people could be resolved. Unlike children, however, the people in respect of

---

[43] *Code of Practice*, para. 13.9b which further makes the point that guardianship does not provide legal authority for removing an unwilling patient from home, unless the patient has absconded from a place where he is required to reside. See para. 4.12 below.

[44] See further Part III.

[45] Consultation Paper No. 128.

whom a judicial forum[46] should have jurisdiction are not immediately identifiable. We therefore attempted to formulate a test of incapacity which might serve to identify those adults for whom such a protective jurisdiction was justifiable, while preserving the principle that capable adults have the right to decide for themselves upon matters which affect their lives.

2.19 We do not think it necessary to repeat in this paper the details of that discussion.[47] We concluded that such a jurisdiction could in general only be justified in relation to people who were both suffering from mental disorder within the meaning of the 1983 Act and unable to take the decision in question. The test of incapacity which we put forward was a specific formulation of the cognitive or "function" test. Our overview paper had stressed that capacity is a legal concept rather than a medical one. Of the various approaches to defining incapacity which were there discussed, the function approach, which looks at the way the decision-maker confronts a particular decision, was most widely favoured by informed commentators.[48] This is usually expressed in terms of the person's capacity to understand the nature and effects of the decision in question. We thought that this concept was better expressed in terms of the ability to process the information relevant to making or not making a particular decision. However, there are also people who can understand and retain the relevant information but because of their mental disorder are unable to conform their actions to it. There are other people who may or may not be mentally disordered, and may or may not be able to understand, but are unable to communicate their decisions to those who could implement them. In our view, people who are incapacitated under that definition ought also to fall within the potential scope of any powers available to public authorities, whether to provide immediate protection against abuse or neglect or to provide longer term services and support in the community. Hence we provisionally propose that:

---

[46] We have not yet put forward proposals as to forum or procedure. For convenience we refer to any new competent authority as a "judicial forum".

[47] See Consultation Paper No. 128, Part III.

[48] Consultation Paper No. 119, para. 2.44. Other options canvassed were identified as the "outcome" approach and the "status" approach. Neither received significant support from our respondents.

2. An incapacitated person is one who is either:

(a) suffering from mental disorder within the meaning of the Mental Health Act 1983 and unable to understand an explanation in broad terms and simple language of the basic information relevant to taking the decision in question, including information about the reasonably foreseeable consequences of taking or not taking it, or unable to retain that information for long enough to take an effective decision; or

(b) unable by reason of his mental disorder to make a true choice in relation to that decision; or

(c) unable to communicate the decision in question to others who have made reasonable efforts [taken all practicable steps] to understand it.[49]

2.20 In relation to the proposed new "private law" jurisdiction we provisionally rejected (1) including an express provision to the effect that a person is not incapacitated simply because he makes a decision which an ordinary prudent person would not make[50] and (2) the inclusion of people who may not fall within the above criteria but who have applied for or consented to the exercise of the new jurisdiction.[51]

Vulnerable people

2.21 To extend the client group beyond the incapacitated to include other vulnerable people within a new public protective framework would involve moving beyond the scope of our project.[52] However, we have already explained why we believe this to be necessary.[53] One

---

[49] Consultation Paper No. 128, para. 3.43.

[50] *Ibid.*, para. 3.25.

[51] *Ibid.*, paras. 3.36-3.38.

[52] Law Com. No. 185, Cm.800 (1989). Item 9 of the Law Commission's Fourth Programme of Law Reform prescribes an investigation into the adequacy of legal and other procedures for decision-making on behalf of mentally incapacitated adults. While some vulnerable people will also be incapacitated many may not. See Consultation Paper No. 119, para. 1.2.

compelling reason for including vulnerable but capable people within a protective jurisdiction is to acknowledge that as a group they are the least well protected in our society under existing law.[54] The powers available to protect both children and the mentally ill are much wider. Yet apart from the statutory provisions discussed in the previous paragraphs vulnerable people, like the incapacitated, have no special protection other than the general law of crime[55] and tort. These may have a general deterrent effect, but in the individual case they operate after the event to exact punishment or compensation. In the case of abuse in the home they must generally be invoked by the victims, who are the least well able to do so. Also, if vulnerable, victims will often be unwilling to invoke the protection of the law through fear of losing their primary carer, fear of further abuse, or of being placed in residential care.

2.22 Vulnerable people are of course not an homogenous group and arriving at a definition of vulnerability which is neither under- nor over-inclusive presents some difficulties. Vulnerability is in practice a combination of the characteristics of the person concerned and the risks to which he is exposed by his particular circumstances. For some it will be the result of physical disability, where the people concerned cannot protect themselves from unwanted restraint. For others, a deterioration of memory or alertness prevents them from asking for the services which would enable them to live as independent a life as possible. Others may be in an abusive relationship with their carer or other person, or otherwise "at risk". We would add to this people who are subject to financial exploitation and abuse.[56]

2.23 The need to move beyond mental incapacity, or even mental disorder, in defining the client group for whom protection should be provided has been identified in other countries.

---

53 See para. 1.6 above.

54 Age Concern, *op. cit.*, p. 29, "An acceptance that some modification or extension to present legislative procedures may be necessary is basic to the argument that a group of vulnerable elderly people are not adequately covered by the protective measures of which others have the advantage."

55 Special protection under the criminal law tends to concentrate on the vulnerable person's capacity to consent to sexual relationships; see Consultation Paper No. 119, para. 2.27 for a more detailed consideration.

56 C. McCreadie, *op. cit.*, one American survey mentioned in the Report revealed that material (financial) abuse accounted for 39% of the abuse identified.

During the 1980s many adult protection statutes were enacted in other jurisdictions.[57] The New Brunswick Family Services Act 1980 (as amended),[58] protects two classes of person. Section 34(1) identifies a "neglected adult" in the following terms:

> "where an adult is a disabled person or an elderly person, or is in a group prescribed by regulation, and
> (a) is incapable of caring properly for himself by reason of physical or mental infirmity and is not receiving proper care and attention; or
> (b) refuses, delays or is unable to make provision for his proper care and attention,
> that person is a neglected adult...."

Section 34(2) identifies an "abused adult":

> "where an adult is a disabled person or an elderly person, or is within a group prescribed by regulation, and is a victim of or is in danger of being a victim of
> (a) physical abuse,
> (b) sexual abuse,
> (c) mental cruelty, or
> (d) any combination thereof,
> that person is an abused adult...."

2.24 The Canadian legislatures adopt a number of different solutions to the problem of adult abuse. The legislation in New Brunswick contemplates specific orders being granted on a one-off basis directing the abused or neglected adult to attend at a certain place or receive certain services. Ontario's Substitute Decisions Act 1992, on the other hand, places protective intervention on behalf of those unable to care for themselves within a guardianship framework.[59] Even where there is urgent need to protect a person incapable of providing for

---

[57] See for example; Newfoundland's An Act Respecting the Welfare of Neglected Adults 1973, Nova Scotia's An Act to Provide for Protection of Adults from Abuse and Neglect 1985.

[58] Formerly the, Child and Family Services and Family Relations Act 1980.

[59] The relationship of our own proposals to the existing guardianship scheme contained in the Mental Health Act 1983 will be explored in Part IV of this Paper.

his personal care, the appropriate procedure is for the Public Guardian and Trustee to apply to the court for an order appointing him as the incapable person's temporary guardian of the person.[60]

2.25 As was said in the overview paper,[61] the powers granted by the existing statutory provisions in Canada are extensive and fairly radical and have been the subject of critical comment, to the effect that they fail adequately to achieve the balance between state protective intervention and the right of the adult to self-determination.[62]

2.26 However, the concept of vulnerability is not unknown to the law in this country. Section 59(1)(c) of the Housing Act 1985 defines a person as having a priority need for accommodation if, inter alia, he or anyone with whom he resides or might reasonably be expected to reside "is vulnerable as a result of old age, mental illness or handicap or physical disability or other special reason".[63] Vulnerability in this context has been held to mean being "less able to fend for oneself so that injury or detriment will result when a less vulnerable man will be able to cope without harmful effects."[64]

2.27 Age Concern have suggested the following definition of vulnerable people for whom local authority support is necessary:

> "[Elderly] people in need of some support, help and/or advice in order to prevent or postpone 'personal or social deterioration or breakdown'."[65]

---

60 Substitute Decisions Act 1992, s.62. This Act received Royal Assent on 10 December 1992.

61 Consultation Paper No. 119, para. 5.5.

62 Gordon, Verdun-Jones and MacDougall, "Reforms in the Field of Adult Guardianship Law: A Comment on Recent Developments", (1987) 6 Canadian Journal of Family Law 149.

63 Larry Gostin, *Mental Health Services - Law and Practice* (1986), para. 4.13.2 notes that the Housing Act 1985 refers to mental illness or handicap (not mental disorder) and that neither term is defined.

64 *R. v. Waveney District Council, ex parte Bowers* [1983] 1 Q.B. 238, 244. The applicant in that case was an alcoholic who had suffered a brain injury. The Court of Appeal held that alcoholism, without more, would not be sufficient to bring his vulnerability within the provision, but that the brain injury did so, whether or not it was classified as a mental handicap.

65 Age Concern, *op. cit.*, p.11.

While this might be an appropriate definition of those who might be eligible for some social services, in the context of specific powers to intervene to provide protection against abuse or neglect, we believe that for the purposes of compulsory procedures this definition casts the net too wide. Many people may be said to need advice in order to prevent some personal or social breakdown, yet this can hardly be a sufficient ground justifying compulsory intervention.

2.28 Many organisations involved in the care of vulnerable people now concentrate on the concept of being "at risk" rather than on the more paternalistic concept of vulnerability. For example, a policy document agreed by various health and social services agencies in Gloucestershire, makes the following general statement:

> "An Adult (18 years or over) who, by reason of frailty associated with ageing, physical or sensory illness or disability, mental illness or learning disabilities (mental handicap) is deemed to be at risk if there has been some significant and avoidable lack of care or ill treatment either through commission or omission by him/her self or others."[66]

The document goes on to list examples of abuse which would justify regarding the person as being at risk.[67] A similar approach has been taken by the Association of Directors of Social Services in their recent guidance on adults at risk.[68] This approach identifies the discrete groups who are most often believed to be in need of protection as:

(a) the elderly and very frail,
(b) those who suffer from mental illness including dementia,
(c) those who have a sensory or physical disability,
(d) those who have a learning disability, and

---

[66] Gloucestershire County Council Social Services, *Adults at Risk* (1992), para. 2.1.

[67] *Ibid.*, para. 2.2; for example physical injury which cannot be satisfactorily explained or physical neglect to such an extent that the person's health and/or development is significantly impaired.

[68] Association of Directors of Social Services, *Adults at Risk* (1991).

(e) those who suffer from severe physical illness.[69]

The document then sets out the types of risk which present the greatest threat to the welfare of the person. The type of risk includes financial and material exploitation and the risk arising from the abuse of drugs and alcohol.

2.29 In our view, it is justifiable to include people who are vulnerable but not incapacitated within the scope of statutory powers of intervention, but only for limited purposes. Vulnerable people belong to those groups for whom local authorities already have a responsibility to provide community care services. They should, therefore, be in need of services because they are aged, or ill, or disabled.[70] However, a simple "status" approach, when outlined in our overview paper,[71] received almost no approval from our respondents. We agree that the status of individuals within a particular client group cannot, without more, justify the use of compulsory powers. Where some-one is incapacitated in the sense which we have already described,[72] it is justifiable to intervene both to protect him from harm and to take decisions on his behalf, whether in the short or the longer term. Where some-one is mentally disordered within the meaning of the Mental Health Act 1983, it may sometimes be justifiable to intervene either in his own interests or for the protection of other people. But where some-one is simply vulnerable, but neither incapacitated nor mentally disordered, it cannot be justifiable to intervene against that person's will. It may, however, be acceptable to provide powers for local social services authorities in order to protect that person from the risk of neglect, abuse or, perhaps, of serious exploitation. That risk will normally arise from the actions of third parties rather than from the vulnerable person himself and it may be presumed, at least until the contrary is shown, that the vulnerable person would welcome the local authority's help. There will also be cases where it is obvious that the person is vulnerable and may be at risk but not yet clear whether or not he is also incapacitated or otherwise mentally disordered. With these limitations on the purposes for which vulnerable

---

[69] *Ibid.*, para. 1.1.

[70] See para. 2.7 above.

[71] Consultation Paper No. 119, para. 2.43.

[72] See para. 2.19 above.

people might be included, we provisionally propose the following definition of "vulnerability" for discussion:

> 3. **A person is vulnerable if by reason of old age, infirmity or disability (including mental disorder within the meaning of the Mental Health Act 1983) he is unable to take care of himself or to protect himself from others.**

The relevant age

2.30 In Consultation Paper No. 128 we proposed that the new "private law" jurisdiction should be available in respect of any person of or over the age of 16.[73] There we noted that care or supervision orders can only be made in respect of children under 17 (or 16, if married), while guardianship becomes available at the age of 16. We see no reason in principle why any new local authority powers to protect incapacitated or vulnerable people should not be capable of being used to protect anyone of or over 16 years of age.[74] This, of course, would not prevent a local authority applying for an order under the Children Act 1989 if this were thought to be the most appropriate way of dealing with the problem at hand. We provisionally propose that:

> 4. **Public law powers should be available to protect incapacitated or mentally disordered or vulnerable people aged 16 and over.**

---

[73] Consultation No. 128, paras. 3.4-3.6.

[74] We realise that the provision of certain community care services is limited to people of or over the age of 18; this is because providing those services for children is now dealt with by the Children Act 1989, which gives greater protection to children who are being looked after by local social services authorities than is given to older recipients of such services. This need not affect the range of protective powers of intervention available, and could be catered for by an appropriate adjustment to the definition of vulnerability in relation to 16 and 17 year olds. Alternatively, the powers proposed in this paper could be limited to incapacitated people aged 16 or over and vulnerable people aged 18 or over. In doubtful or borderline cases, however, this could give rise to considerable practical difficulties.

PART III

INVESTIGATION, ASSESSMENT AND SHORT TERM INTERVENTION

Introduction

3.1 In this part we examine the range of powers that a public authority might require in order to ensure that those incapacitated or vulnerable people who are at risk or in need of care receive the necessary protection and services. Any discussion of such powers must be seen against the background of their existing obligations to provide community care services.[1]

3.2 For the purposes of investigating allegations of abuse and assessing the person's need for services the existing powers under the National Assistance Acts and Mental Health Act 1983 could be integrated into a new framework catering for all incapacitated, vulnerable or mentally disordered people. Alternatively, the existing provisions of the 1983 Act could be left much as they stand to cater for mentally disordered people and completely new statutory provisions could be made for the incapacitated and vulnerable people identified in Part II of this paper. We invite views on this but we tend to the view that the second approach is preferable. People who are mentally disordered but not incapacitated fall within our proposed definition of vulnerability in any event. It would be much easier for social services authorities and their clients if there were a single set of short term protective measures available to help all their vulnerable clients. As will be seen, the machinery which we provisionally propose is very similar to, but in our view a considerable improvement upon, that which already exists in section 135 of the 1983 Act.

3.3 It may help if we summarise at the outset the main elements in that machinery and how we see these applying to incapacitated, mentally disordered and vulnerable people respectively. We believe that the present powers concentrate unduly on removing the client

---

[1] See paras. 2.2 to 2.8 above.

from home, which may do more harm than leaving him in his present situation. A more flexible range of powers is needed which provides opportunities for resolving matters without resorting to this drastic solution. Some respondents to our overview paper urged upon us the merits of devising for this purpose procedures similar to those for the protection of children under the Children Act 1989. While there are many respects in which the needs of incapacitated and vulnerable adults are different from those of children, we agree that, with suitable adaptions, those procedures do form a sensible model.

3.4 Hence we propose that there should be powers (and indeed duties) of *investigation* in cases of suspected abuse or neglect which should apply to all three client groups. These may include powers to gain *entry to premises* and *access to the client*, at least until it is known whether or not he is at risk, whether he is or may be incapacitated or mentally disordered, and if he is neither of these, whether he objects to the authorities' efforts to help. It should also be possible to obtain an order providing for an *assessment* of the client's capacities and needs or for the *removal* of the client from home to a safer place in all three cases, but these powers should not be exercised against the will of a person who is vulnerable but neither incapacitated nor mentally disordered. It follows that applications should not be made in cases where such a person is known to object, but may be made where his attitude is not known or it is thought that he would not object on this occasion.

Recent proposals

3.5 The range of powers which should be available to a local social services authority has recently been considered by, amongst others, Age Concern[2] and the British Association of Social Workers (BASW).[3] The powers recommended by Age Concern are intended to be used by local authorities in discharging their general duty to promote the welfare of elderly people. The legislative proposals of BASW have been formulated as a general framework for the protection of disabled "adults at risk" which could be invoked by the local authority or any concerned person.

---

[2] Age Concern, *The Law and Vulnerable Elderly People* (1986).

[3] British Association of Social Workers, *Draft Legislation in relation to Adults at Risk* (1990).

3.6 In addition to a general duty to promote the welfare of vulnerable people and to carry out an assessment of their needs, Age Concern recommended that there should be two court orders available, an intervention order and an emergency intervention order. Age Concern say of the latter, "In exceptional circumstances of emergency when immediate action was needed to relieve a situation of immediate grave risk, direct application to the court could be possible without preliminary intervention by the local authority."[4] The directions which the court would be able to make under this order include the power to gain access to the client or to remove him if necessary; they do not contain powers to require the person to comply with a request for an assessment, including a medical examination.

3.7 The emergency order contemplated by BASW envisages far less intervention than that advocated by Age Concern. Where the court receives information on oath that a person with a disability, in respect of whom an application for the appointment of a temporary guardian has been made, is being unlawfully detained, or is likely to suffer significant harm if immediate action is not taken, then the court may require the local authority to visit the disabled person and present a report to the court within 72 hours. Once the report has been presented to the court further powers are available, such as a power to exclude an abuser from the home.

3.8 Under Age Concern's proposed "intervention order" an application could be made in two situations. The first is where the local authority have refused to consider, or after consideration, have failed to respond appropriately in their duty to promote the welfare of the vulnerable elderly. We do not, however, consider it appropriate as part of this project to contemplate the possibility of courts ordering local authorities to provide specific services for particular individuals.[5] The second situation in which an application could be made is where the local authority have formulated a plan on the grounds that it was necessary and in the best interests of the (elderly) person but where he has refused its implementation. The local

---

[4] Age Concern, *op. cit.*, p. 135.

[5] The situation is covered by the complaints procedure set up under the National Health Service and Community Care Act 1990, s.50; see paras. 3.51-3.52 below. There is also the possibility of judicial review of a decision of the local authority not to carry out an assessment or to provide certain services.

authority would have the right to go to court to ask for any of several orders.[6] These would not, however, enable the authority to implement the plan without the person's consent.

3.9 The BASW approach to non-emergency orders is framed within a guardianship structure. One of the attractive features of the BASW proposal is that it allows the court to make a range of orders "according to each individual's needs." The range of orders which the court may make, available on application by a local authority or any concerned person, is as follows:

(a) a contact order,
(b) a prohibited steps order,
(c) a residence order,
(d) a specific issue order,
(e) an administration order (for management of finances) and
(f) a limited guardianship order.

3.10 These mirror very closely the proposals made in our consultation paper on a new jurisdiction.[7] We believe that these types of powers should be dealt with within a longer term plan for the care of the incapacitated or mentally disordered client. Our concern here is with the powers which are necessary in order to carry out the initial investigation and assessment of the capacity and needs of these and other vulnerable people. The powers we think should be available at this stage are those relating to access, entry, examination and assessment, and removal. Removal should always, in our view, be regarded as a last resort.

---

6 Age Concern, *op. cit.*, p.135. The orders are listed as follows:
(i) that the arrangements for the care of the old person ... are satisfactory,
(ii) that the local authority ... be recommended to take such steps as the court deems necessary, with the old person's consent, to secure the well-being and necessary care and attention of that person;
(iii) that reports ... be made to the court ...;
(iv) ... that a representative of the old person be appointed ...;
(v) that the matter be referred to the Court of Protection.

7 Consultation Paper No. 128; see further in Part V below.

The responsible authority

3.11 We referred in the overview consultation paper[8] to the confusing division of responsibility which exists in relation to the powers under section 47 of the National Assistance Act 1948 and the possibility that the social worker involved with the person is not involved in the decision to remove the person from home.[9] We believe that it is essential for a single agency to be responsible for the initiation of the investigative and assessment process. As social services departments are responsible under the 1990 Act for the provision of community care services we believe they should be the responsible agency, although they should also have a duty to consult other relevant authorities. Accordingly we provisionally propose that:

1. **The local social services authority should be the agency responsible for investigating allegations of neglect or abuse of an incapacitated, mentally disordered or vulnerable person.**

3.12 A second question which arises is who should have responsibility for initiating any further action should the investigation of suspicions of abuse or neglect reveal this to be warranted. Once again, the local social services authority would appear to be the obvious body to undertake this. The compulsory powers which we propose later in this paper are simply the necessary reinforcement of their existing responsibilities in relation to disabled, elderly and mentally disordered people, together with the more precise duties to investigate allegations of abuse and neglect which we also propose.[10] Social services authorities already fulfil this protective role in relation to children. Furthermore, it is their accommodation and facilities which are most likely to be required. However, under the existing law, the district community physician is also entitled to initiate protective action.[11] We would therefore welcome views on whether it should be possible for a district health authority, or an officer

---

8 Consultation Paper No. 119, para. 3.21, see also para. 2.10 above.

9 See paras. 2.10-2.11 above.

10 See paras. 3.14-3.17 below.

11 Under the emergency procedure provided for by the National Assistance (Amendment) Act 1951.

authorised by that authority, also to initiate the procedures recommended below. We believe, however, that the most sensible and efficient solution would be for the primary responsibility to lie with the local social services authority. We therefore provisionally propose that:

2. The local social services authority should also be the agency responsible for initiating proceedings in relation to the care and protection of incapacitated, mentally disordered or vulnerable people.

3.13 A further question is how those responsibilities should be exercised on behalf of the local authority. Under the Children Act 1989, anyone can apply for an emergency protection order under section 44, but only a local authority or authorised person[12] can apply for a child assessment order under section 43 or for a care or supervision order under section 31. The powers given by or under the Act to enter and inspect certain premises are exercised by officers of the local authority who are authorised for the purpose.[13] Under the Mental Health Act 1983, on the other hand, certain powers of entry and application are given, not to the local authority as such, but to an approved social worker.[14] It is not for us to make recommendations about the extension of the concept of the approved social worker into other areas of social work practice. We suggest that the powers proposed below could, where necessary, be exercised by any officer of the local social services authority who is authorised by the authority for that purpose.

Investigation of neglect or abuse

3.14 The duty placed on local authorities by section 47 of the National Health Service and Community Care Act 1990[15] is to assess those who appear to be in need of community care

---

12 Meaning either the N.S.P.C.C. or any person authorised by the Secretary of State for this purpose or any officer of a body which is so authorised: 1989 Act, s.31(9).

13 See, e.g., the powers relating to privately fostered children, in the 1989 Act, s.67(3).

14 Appointed by the local social services authority under the 1983 Act, s.114(1); no person can be appointed unless approved by the authority, which must have regard to the matters directed by the Secretary of State, as having appropriate competence in dealing with persons who are suffering from mental disorder; *ibid.*, s.114(2) and (3).

15 See para. 2.4 above.

services. This may arise, for example, where the local authority are already providing services to a client or where the client or carer has made an application for an assessment. Under the terms of their new contracts with the National Health Service all General Practitioners are under an obligation to refer patients to the local authority if the GP believes the person to be presenting a need for services.[16] With the effective operation of these various referral systems the majority of those who may need local authority services should be identified.

3.15 This duty is not, however, specifically aimed at the investigation of cases of suspected abuse and neglect. Under section 47(1) of the Children Act 1989, where a local social services authority are informed of a child living or found in their area who is the subject of an emergency protection order or in police protection under the Act, or they have reasonable cause to suspect that a child living or found in their area is suffering, or is likely to suffer, significant harm, the authority are required to "make, or cause to be made, such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare". The section goes on to detail the purpose of these enquiries and the steps which must be taken to pursue them. These include trying to obtain access to the child and seeking an order if this is denied. Having embarked upon an enquiry, the authority are required to come to some sort of conclusion and to act upon it. Other public authorities are required to co-operate with those enquiries if asked. There may be a case for some comparable provision in relation to incapacitated or vulnerable adults who are believed to be "at risk".

3.16 There are at least two ways of approaching the question of whether an adult is "at risk" for this purpose. One is to refer to the risk of ill-treatment, abuse or neglect, including self-neglect. The other is to refer to the risk of harm. We believe that the concept of "significant harm" which is used for the purpose of protecting children is just as applicable to incapacitated and vulnerable adults. "Harm" for this purpose means "ill-treatment or the impairment of health or development"; "ill-treatment" includes sexual abuse and forms of ill-treatment which are not physical; "health" means physical or mental health; and

---

[16] GPs and other health care professionals will also often be part of the assessment team.

"development" means physical, intellectual, emotional, social or behavioural development.[17] There may not be much to choose between the two approaches in practice, but there are several reasons for preferring the second. First, it tries to define what is meant by abuse or neglect (which are usually left undefined); secondly, it concentrates on the suffering of the victim rather than the conduct of others (who in these cases are often placed under intolerable pressure by their situation); and thirdly, the social services are becoming increasingly familiar with the concept of significant harm[18] (which appears to be working well in the child care context). However, incapacitated, elderly or disabled adults may also be vulnerable to forms of exploitation which might not immediately be thought to fall within the concept of ill-treatment. An obvious example is financial exploitation but another might be the degradation or exposure to ridicule involved in being made to take part in certain kinds of exhibition. Bearing in mind that a vulnerable person who turns out not to be incapacitated is entitled to refuse the help which is offered,[19] it seems justifiable to provide for the possibility of protection from serious exploitation as well as significant harm. We therefore invite views upon the following provisional proposal:

> 3. **Where a local authority have reasonable cause to suspect that a person is incapacitated, mentally disordered or vulnerable and is suffering or is likely to suffer significant harm [or serious exploitation], they should be under a duty to make such enquiries as they reasonably can, including taking steps to gain access to that person, and to decide whether they should take any action to provide community care services for that person or otherwise protect him from harm [or exploitation].**

3.17 The object of such a provision would be to strengthen the responsibility of local social services authorities to provide positive protection for incapacitated or vulnerable people who are at risk of abuse or neglect. In theory, it would do little to change the extent of their

---

[17] Children Act 1989, s.31(9).

[18] Research into the concept of significant harm under the the Children Act is currently being carried out at the University of East Anglia by Dr June Thoburn and colleagues.

[19] See para. 2.29 above.

existing responsibilities as service enablers and providers. The duty imposed upon a local authority by section 47 of the 1990 Act arises "where it appears to a local authority that any person for whom they may provide community care services may be in need of any such services...." However, the nature, purpose and possible conclusion of an assessment of needs is quite different from the nature, purpose and possible conclusion of an investigation of abuse. The latter should be quicker, more narrowly focused, include consideration of whether short or even longer term compulsory steps are needed, and aimed at providing any necessary protection, which may or may not involve the provision of community care services.

Mandatory reporting

3.18 The existing law in England and Wales neither confers a positive right nor imposes a positive duty on any person or organisation to report suspected abuse or neglect of incapacitated or vulnerable adults. Whether there should be such a right or duty imposed upon professional persons is a controversial question, touching as it does on the issue of confidentiality. Canadian legislation which does impose such a duty protects the communicator of such information from an action for breach of confidence.[20] We do not support the view that a general duty to report should be incorporated into English law.[21] Nor do we think a specific duty should be imposed on public authority personnel and social services and health care professionals.

3.19 The issue of reporting suspected child abuse was examined in the *Review of Child Care Law*.[22] The conclusion was that there was no demonstrable need for a mandatory reporting law in England and Wales. The conditions which exist in the United States of

---

[20] See for example Newfoundland's Neglected Adults Welfare Act 1973, s.4 of which requires anyone with information that a person is a neglected adult to pass such information to the appropriate authority. Subsection (2) reads; "Subsection (1) applies notwithstanding that the information is confidential or privileged, and no action lies against the informant unless the giving of the information is done maliciously or without reasonable and probable cause."

[21] In relation to children no duty to report suspected child abuse to appropriate authorities is placed either on health professionals or members of the public. Professional codes of practice govern the way in which such groups are expected to deal with this issue.

[22] DHSS, *Report to ministers of an interdepartmental working party* (1985).

America where mandatory reporting has its longest history are not the same in this country.[23] Most professionals in this country who might be covered by a mandatory reporting law are publicly employed and are imbued by their training, tradition and the character of their work with a strong emphasis on the welfare of their clients. Decisions as to when to report suspicions of abuse or neglect are matters which are probably best left to codes of practice issued by the various professional bodies.

Case conferences

3.20 The system of case conferences in cases of suspected child abuse and neglect is now firmly established on a regular but non-statutory footing. It has been put to us that, as is the case with decisions made in relation to possible reception into Mental Health Act guardianship,[24] case conferences should be held before any decisions are made as to the intervention required to provide an incapacitated or vulnerable person with the appropriate level of care and protection. Of course it will not always be possible to hold a multi-disciplinary case conference before the event, for example where it appears to the local authority that immediate action is needed. In such a situation, the local authority may still consult, as far as is practicable, with other agencies.[25] This is a matter of good practice rather than legislative reform. Nevertheless, we invite comments on whether or not it would be appropriate for there to be guidance on suitable case conference procedures, equivalent or similar to those now in use for the protection of children, when a local authority are considering the exercise of compulsory powers in respect of an incapacitated, mentally disordered or vulnerable person.[26]

---

[23] *Ibid.*, para. 12.3.

[24] *Code of Practice*, para. 13.3.

[25] Even in an emergency the rationale for calling a case conference still exists to some extent, that is, that the local authority is unlikely to be the sole repository of knowledge and wisdom about the individual concerned. A case conference should be called as soon as the emergency is over where further intervention is anticipated.

[26] See Department of Health, *Working Together* (1991), Part VI.

At risk register

3.21 It has also been suggested[27] that as a matter of good practice the local social services departments should establish an "at risk" register for incapacitated or vulnerable people as they do for children.[28] This was also supported by one of our respondents, who thought that this would ensure that knowledge of abuse was official and that there would be a focal point for the collection of information. Objections to this could be made on the grounds that it stigmatises a person as in need of protection when in fact the local authority consider that no further action is at that time appropriate.

3.22 Registers are not only useful in protecting the incapacitated or vulnerable from abuse. They can also be used to record those people for whom the local authority has a duty or a power to provide services. Section 1(1) of the Chronically Sick and Disabled Persons Act 1970 requires the local authority to inform themselves of the number of persons to whom section 29 of the National Assistance Act 1948 applies.[29] To this end local authorities are required to set up registers of disabled people.[30] We invite comments on the desirability of setting up registers of those incapacitated, mentally disordered or vulnerable people about whom the local authority are concerned because they may not be receiving adequate care or they may be being abused.[31]

---

27 Association of Directors of Social Services, *op.cit.*, para. 7.1.12.

28 The Department of Health in *Working Together*, para. 6. 36 say of the child protection register, " This is not a register of children who have been abused but of children for whom there are currently unresolved child protection issues and for whom there is an inter-agency plan."

29 Section 29 states that the local authority may, with the approval of the Secretary of State, and to such extent as he directs must, make arrangements for promoting the welfare of persons who are blind, deaf or dumb, or who suffer from mental disorder of any kind, and persons who are substantially handicapped and permanently handicapped by illness, injury or congenital deformity or such other disabilities as the Secretary of State may prescribe.

30 DHSS circular (45)71. See also section 6(1) Disabled Persons (Employment) Act 1944 which requires the Minister to establish a register of disabled persons for the purposes of employment.

31 British Association of Social Workers have recently called for the abolition of registers of the disabled on the grounds that they are useless and demeaning. See Social Work Today, 26 November 1992, p.6.

Powers of entry and rights of access

3.23 An initial problem with the investigation of suspected abuse or neglect arises when the authorities are unable to gain access to the home in order to carry out an investigation and assessment. In such cases, the obstacle may well be the suspected victim's family or carer rather than the victim himself. A similar problem may arise in cases where the local social services authority believe that there may be a need for community care services even though there is less reason to suspect abuse or neglect. In this context the obstacle to assessing the client's needs is more likely to be the person concerned. In what circumstances should the local authority have a right to see and interview the person concerned? And should unreasonable interference with the exercise of such a right by a third person be an offence, along the lines of section 129 of the Mental Health Act 1983?[32]

3.24 There is no explicit right of access to a "patient" in the Mental Health Act 1983 but there is a power to enter premises where a "patient" is residing. Section 115 of the Act authorises an approved social worker to enter and inspect any premises, other than a hospital, in which a mentally disordered patient is living if he has reasonable cause to believe that the patient is not under proper care. Richard Jones has noted that the section uses the term "mentally disordered patient".[33] Perhaps surprisingly, it does not use the wider term 'patient' which also includes those *appearing* to be suffering from mental disorder.[34] The implication may be that this power was intended to be used to monitor the welfare of people who were already known to be mentally disordered. It can only be exercised at reasonable times.[35] It does not permit the social worker to force entry onto the premises although obstruction of the

---

[32] See para. 3.26 below.

[33] R. Jones, *Mental Health Act Manual* (3rd ed. 1991), p. 191.

[34] 1983 Act, s.145(1).

[35] 1983 Act, s.115(1). And on production, if asked, of some duly authenticated document showing that the person requiring entry is an approved social worker.

exercise of this power, without reasonable cause, is an offence.[36] If entry is refused a warrant may be obtained under section 135 of the Act.[37]

3.25 We believe that this power, or its equivalent, could usefully be adapted to provide protection for a wider group of people. It could provide for a right of entry to premises where a person who is believed to be incapacitated, mentally disordered, or vulnerable, is living, provided of course that there were also reasonable grounds to suspect that person was in some way at risk. Such a power could be coupled with a right to see the person concerned. The object would be to overcome the reluctance, not so much of the incapacitated person himself, but of the carer or other third person who is obstructing access to him. The threat of a criminal sanction as a result of an unreasonable obstruction of access would also be of great persuasive effect. We therefore provisionally propose that:

4. An officer of the local social services authority, authorised for this purpose, should have power to enter premises where any person believed to be incapacitated, mentally disordered or vulnerable is living, if there is reasonable cause to suspect that that person is suffering, or likely to suffer, significant harm [or serious exploitation].

Refusal of access

3.26 Section 129 of the Mental Health Act makes it an offence for any person without reasonable cause to refuse to allow the inspection of any premises[38], or the visiting, interviewing or examination of any person by a person authorised in that behalf[39] by or

---

36 1983 Act, s.129(1). See para. 3.26 below.

37 See para. 2.12 above.

38 1983 Act, s.129(1)(a).

39 Those authorised under the Act are a registered medical practitioner who seeks to examine a patient for the purposes of advising the nearest relative as to the exercise of his power to order the patient's discharge, s.24; an approved social worker who seeks to enter and inspect premises, s.115; and the Mental Health Act Commissioners in respect of their duty, on behalf of the Secretary of State, to visit and interview patients detained under the Act, s.121(2)(b) and S.I. 1983, No. 892, art. 3(2)(c).

under the Act,[40] or otherwise to obstruct any such person in the exercise of his functions.[41] If those functions are to be extended in the way proposed above, it would be logical to extend this offence. Accordingly, we provisionally propose:

5. **It should be an offence (equivalent to that in section 129(1) of the Mental Health Act 1983), without reasonable cause, to refuse to allow an authorised person to enter and inspect premises, or to have access to the person believed to be at risk, or otherwise to obstruct the exercise of the powers provided for in proposal 4 above.**

Entry warrants

3.27 If entry to premises, or access to the person believed to be at risk, is denied, the threat of criminal sanctions may not be sufficient to provide the necessary protection. The existing power to obtain entry by force is contained in section 135(1) of the Mental Health Act 1983. No power of entry exists under section 47 of the National Assistance Act 1948, although without it the section may be extremely difficult to use.

3.28 Under section 135(1)[42] of the 1983 Act, if it appears to a justice of the peace, on information on oath laid by an approved social worker, that there is reasonable cause to suspect that a person believed to be suffering from mental disorder:

> "(a) has been, or is being, ill-treated, neglected or kept otherwise than under proper control..., or
>
> (b) being unable to care for himself, is living alone...."

---

[40] 1983 Act, s. 129(1)(b).

[41] 1989 Act, s.129(1)(c).

[42] Section 135(2) contains provisions for entry into premises where it is believed that a person who is liable to be detained under the Act is residing.

the justice may issue a warrant authorising a named constable to enter the premises where that person is believed to be,[43] by force if necessary, and if thought fit to remove him to a place of safety.[44] The constable must be accompanied by an approved social worker and a doctor.[45] If removed the person may be detained in a place of safety for no more than 72 hours.[46] Removal should be with a view to making an application for the person's admission to hospital under the 1983 Act[47] or of other arrangements for his treatment or care.

3.29 In several of the Canadian jurisdictions a power of entry can be granted to the designated authority. Under section 35(3) of the New Brunswick Family Services Act 1980, where the person believed to be an abused or neglected adult or any person having care and control of such a person obstructs the carrying out of an investigation, the Minister may issue a warrant authorising entry, by force if necessary, to any building in order to carry out an investigation as to whether the person is an abused or neglected adult.[48]

3.30 Section 135(1) of the 1983 Act is limited to those who are believed to be suffering from mental disorder. It is not possible to use this power to protect or to assess the needs of people who appear to be incapacitated but who are not also believed to be suffering from a mental disorder. If the definition of incapacity which we have proposed earlier is accepted,[49] there will be a few incapacitated people who are not necessarily suffering from mental

---

43 The premises must be specified in the warrant (1983 Act, s.135(1)) but it is not necessary to name the person concerned (1983 Act, s.135(5)).

44 A "place of safety" for this purpose means residential accommodation provided by a local social services authority under Part III of the National Assistance Act 1948, a hospital as defined in the 1983 Act, a police station, a mental nursing home or residential home for mentally disordered persons, or any other suitable place the occupier of which is willing temporarily to receive the patient (1983 Act, s.135(6)).

45 1983 Act, s.135(4).

46 1983 Act, s.135(3).

47 1983 Act, ss.2 - 6.

48 Similar powers exist in the other Canadian legislation to which we have referred, see s.8(2) of the Act to provide for Protection of Adults from Abuse and Neglect 1985 (Nova Scotia) and s.5(2) of An Act Respecting The Welfare Of Neglected Adults 1973 (Newfoundland).

49 See para. 2.19 above.

disorder but who are unable to communicate their decisions. There may also be a need for a similar power to reinforce the right of access to vulnerable people who are believed to be at risk of abuse or neglect even though they are not incapacitated or mentally disordered. In this case, we believe that it is reasonable to assume that the person would want to be helped. However, where it is not possible to make that assumption, serious questions arise as to the propriety of action taken to help a vulnerable person who is neither incapacitated nor mentally disordered against that person's wishes.[50] That is so, not only in respect of the power to gain entry, but also of the powers that we later provisionally propose for assessment and emergency protection orders. We welcome views on whether such powers should, in any circumstances, be exercisable in the case of vulnerable but neither incapacitated nor mentally disordered people known to object.[51] We tend to the view that it would never be right to exercise any of these powers in such cases. A person's attitude may well change, however, so that an objection to help in the past should not necessarily be taken as an indication that it would be resisted on this occasion. We therefore provisionally propose that:

6. **An officer of the local social services authority, authorised for this purpose, should be able to apply for a warrant authorising a constable, accompanied by that officer, to enter any premises, by force if necessary, where there is reason to believe that a person who is believed to be incapacitated, mentally disordered or vulnerable, is suffering or is likely to suffer significant harm [or serious exploitation] [and, in the case of a vulnerable person, that he would not object to such entry being gained on this occasion].**

3.31 In some cases there may be an immediate risk of harm which is so severe that there should be a power to enter without warrant. The police already have power to enter any premises for the purpose of saving life or limb.[52] We do not believe that there is need for any further statutory powers of entry without warrant.

---

50 See paras. 1.16 and 2.29 above.

51 See Part VI below.

52 Police and Criminal Evidence Act 1984, s.17(1)(e).

Examination and assessment

3.32 Once access to the client has been gained the next step is to interview him to discover what the position is. It may be that once entry has been achieved it will become clear that he is in good health and neither incapacitated, mentally disordered nor vulnerable. Refusal to co-operate with the local authority may be based on a wish to be left untroubled by outside help. In such cases the proper course for the local authority is to comply with the wishes of the person and leave him alone. Where on gaining entry it appears that the person concerned may be incapacitated or mentally disordered and is not being cared for properly, then further action should be taken. However, if the person concerned is merely vulnerable and declines the offer of assistance, again the proper course would be to comply with those wishes.

3.33 One difficulty with the present law is that it contains no formal machinery for carrying out an assessment of a person's capabilities and needs. Where opposition is encountered, whether from the family or carers or the person himself, there is no half-way house between leaving the person alone and removing him from home. We envisage that two types of orders might become available. One could be used to enable the local authority to carry out an assessment of the needs of the client in a situation where significant harm does not appear imminent. The second order would be available to deal with the situation where such harm is directly apprehended. As elsewhere in this project, the provisions of the Children Act 1989 may be a useful model on which to build.

3.34 Where there appears to be no need for emergency action to be taken, we propose that there should be a power to apply to the court for an order along similar lines to a child assessment order under section 43 of the Children Act 1989. Such an order would be designed to enable the local authority to carry out a multi-disciplinary assessment of the capacities and needs of a person whom they believe to be incapacitated, mentally disordered or vulnerable. Although in principle a vulnerable but capable person should be allowed to decline their help, at the stage when the authority are applying for the order it may not be clear whether the obstacle is the person concerned or the people who are looking after him. As with a child assessment order, the authority would be expected to present the court with a clear plan as to how the assessment would be carried out, and the order would define

exactly what was required. Again, as with a child assessment order, the person concerned would be entitled to decline the examination or assessment if he had sufficient understanding to make an informed choice on the matter.[53] The order would be of limited duration, certainly for no longer than seven days,[54] lasting only as long as is necessary to assess the client's capacity and need for services and to determine whether any further and longer term intervention is necessary. It might include requirements upon the carer or the person concerned, either to receive visits or attend at a clinic or day centre for assessment, but it would not normally require the person to leave home.[55] Hence we provisionally propose that:

7. The local social services authority should be able to apply for an order of limited duration authorising them to carry out an assessment of the capacity and needs, either for protection or for community care services or both, of any person they have reasonable grounds to believe is incapacitated or mentally disordered or vulnerable and is suffering or is likely to suffer significant harm [or serious exploitation] and, in the case of a vulnerable person, that he would not object to the order being made.

3.35 Other jurisdictions with adult protection statutes routinely include within the power to assess a further power to compel the person to submit to a medical examination.[56] Whether a medical[57] examination is a necessary part of any effective assessment of capacity is a question on which we invite comment. Our initial view is that a medical assessment will

---

53 Children Act 1989, s.43(8).

54 *Ibid.*, s.43(5).

55 Under a child assessment order, the child may only be kept away from home if it is necessary for the purposes of the assessment and in accordance with directions and for the period(s) specified in the order (1989 Act, s.43(9)).

56 New Brunswick's Family Services Act 1980, s.35(1) allows the Minister to authorise a medical practitioner to examine and report on the physical and mental condition of the person believed to be a neglected or abused adult. Section 35(2) says that "The authorisation of the Minister ... is sufficient authority to any medical practitioner to perform ... [the examination] ... without the consent of the person being examined."

57 In this context 'medical' is used in its widest sense to include psychiatric evaluation.

be necessary in order for certain compulsory interventions to be lawful.[58] We welcome comments on whether there should be a power to examine and to which client groups such a power should apply.

Emergency protection order

3.36 There clearly are some circumstances in which it is necessary for the authorities to have power to remove people from a place where they are or may be being neglected or abused. We would only expect this to happen against the wishes of the person concerned in the most exceptional circumstances and when all other means of assisting the person have failed. Removal not only involves an infringement of the right to self-determination but may be a violation of the individual's right to liberty and security of person which is guaranteed under the European Convention of Human Rights. Under Article 5(1) of the Convention, "no one shall be deprived of his liberty save in the following cases ...." Deprivation of liberty is a question of degree.[59] The only permitted exception which could be relevant is "(e) the lawful detention of persons for the prevention of spreading diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants." In the *Winterwerp*[60] case it was held by the Court that the requirement that the detention must be "lawful" means that it must have taken place in accordance with the procedural and substantive provisions of municipal law and must meet the purpose for which Article 5(1)(e) has been drafted. Detention on the basis of "unsound mind" must satisfy three minimum conditions:

1. the person must be reliably shown to be of unsound mind (which calls for objective medical expertise),

---

58 See further paras. 3.36-3.37 below.

59 See *Case of Engel and Others v The Netherlands (No. 1)* [1979-80] 1 E.H.R.R. 647 and *Guzzardi v Italy* [1981] 3 E.H.R.R. 333.

60 *Winterwerp v The Netherlands* [1980] 2 E.H.R.R. 387. It was said of the term 'unsound mind', that it cannot be given a definitive interpretation as it is a term whose meaning is continually evolving as research in psychiatry progresses.

2. the nature or degree of the mental disorder must be such as to justify the deprivation of liberty, and

3. the continued confinement is only valid as long as the disorder persists.

3.37 We believe that the test of incapacity[61] or mental disorder which we have proposed for the exercise of the powers proposed in this paper would meet the requirements of the European Convention. In some cases of short term removal, especially in an emergency, the presence of incapacity or mental disorder may not yet have been proved. However, the *Winterwerp* case allows for this possibility. Provided that there are reasonable grounds for believing the person to be incapacitated or mentally disordered, we believe that a power to remove and detain for a limited period would not result in a breach of our obligations under the Convention.[62] No such justification exists in relation to people who are merely believed to be vulnerable, rather than incapacitated or mentally disordered, and who do not wish to be removed. The extension of these powers to such persons would, therefore, not only give rise to the general issue of policy to which we have already referred,[63] but would also raise serious questions under the Convention.[64] However, as with an assessment order, an application might have to be made in circumstances of grave risk where the person concerned might well be unable to protect himself and would welcome such intervention on his behalf. Accordingly we provisionally propose that:

---

61 See para. 2.19 above.

62 Support for this can be found in the *Winterwerp* case at para. 39 where the Court states, " In the Court's opinion, *except in emergency cases*, the individual concerned should not be deprived of his liberty unless he has been reliably shown to be of 'unsound mind'", (emphasis added). Later at para. 42 the Court states, "While some hesitation may be felt as to the need for ... (emergency) ...detention to continue for as long as six weeks, the period is not so excessive as to render the detention 'unlawful'." While it is to be admitted that this case concerns detention rather than the initial decision to remove, we believe the basic proposition of ECHR law to remain valid in relation to removal.

63 See paras. 1.16 and 2.29 above.

64 Much might depend, in any given case, on the extent to which the exercise of the power was thought to be a significant and relevant deprivation of liberty. Only very limited guidance is available on this point: see for instance the cases cited in para. 3.36, n. 59 above; and any further views on this issue would be welcome.

8. **The local social services authority [or an officer authorised for the purpose] should be able to apply for an emergency protection order authorising them to remove to a place of safety a person believed to be incapacitated or mentally disordered or vulnerable where there are reasonable grounds to believe that that person is likely to suffer significant harm [or serious exploitation] if not removed and, in the case of a vulnerable person, that he would not object to the order being made.**

3.38 As is common in emergency situations, we believe that it should be possible to make an application ex parte. However, while we see the merit in the argument of Age Concern that many of the usual procedural steps may have to be dispensed with in an emergency, we agree with ADSS that there should normally be consultation with other bodies before any application is made.[65] We provisionally propose that:

9. **Applications for an emergency protection order may be made *ex parte* if need be.**[66]

Duration

3.39 We propose that removal under this power should be for no longer than seven days and we invite views on whether a shorter period would be more appropriate. This is longer than the period of 72 hours currently allowed under section 135(1) of the Mental Health Act 1983 but shorter than the period allowed under the National Assistance Acts.[67] It is necessary to balance the time which may be required to carry out a proper examination and assessment of the person's needs and to make the necessary arrangements against the

---

[65] ADSS, *Adults at Risk* (1991), at 7.1.12, " The urgency of the situation might not allow time for a case conference before action is taken, but no matter how little time is available, other social services' colleagues and colleagues from other relevant services, notably the health service, including general medical practitioners and the police, should be consulted, if necessary by telephone."

[66] See para. 3.44 below.

[67] The maximum period in s.47 of the National Assistance Act 1948 is three months, but this may be extended for further periods of three months; the maximum period under the emergency procedure provided for by the National Assistance (Amendment) Act 1951 is three weeks.

difficulties of re-establishing the person back at home once such a drastic step has been taken. The period of seven days is also consistent with the maximum initial duration of an emergency protection order under the Children Act 1989. Hence we provisionally propose that:

10. A person who is taken to a place of safety under the power proposed above may be kept there for a maximum period of seven days.

Which premises?

3.40 Under section 47 of the National Assistance Act 1948 a person may be taken to a "suitable hospital or other place"; in practice, this is usually a local authority old people's home. A "place of safety" for the purpose of section 135 or 136 of the Mental Health Act 1983, is defined as "residential accommodation provided by a local authority under Part III of the National Assistance Act 1948, a hospital as defined by this Act, a police station, a mental nursing home, a residential home for mentally disordered persons or any other suitable place the occupier of which is willing temporarily to receive the patient."[68] This definition would appear entirely appropriate for any revised scheme.

Duty to return home

3.41 Where a person has been removed from home in this way we believe that every effort should be made by the local authority to return the client to his own home when this can safely be achieved with the provision of appropriate services. We therefore provisionally propose that:

11. Where a person has been removed from home under an emergency protection order, the local authority should have a duty to return him as soon as it appears to them that he will not be at risk if this is done.

---

[68] Mental Health Act 1983, s.135(6).

Power to treat

3.42 The power to treat patients detained under the Mental Health Act 1983 without their consent[69] does not apply to people detained under section 135.[70] Although it appears that the National Assistance (Amendment) Act 1951 was passed because a doctor had been unable to persuade a person with a broken leg to go to hospital for treatment,[71] and the declared purpose of section 47(1) of the National Assistance Act 1948 is to secure the "necessary care and attention" for the people concerned, the court order simply authorises the person's removal to the hospital or suitable place and "detention and maintenance therein". These days such a provision would not be construed so as to allow a person to be given medical treatment, whether for a physical or mental disorder, against his will. The whole subject of medical treatment of incapacitated people is dealt with in a separate paper and we make no further proposals about it here.[72] The powers which we have proposed should not be taken to imply a power to treat.

Appeal against an emergency protection order

3.43 No appeal lies from either a decision to make or a refusal to make an emergency protection order under the Children Act 1989.[73] We welcome comments on whether appeals against the making or refusal to make an emergency protection order should be permitted. We believe that in many respects an appeal would be impracticable in view of the intended limited duration of the order.[74]

---

69 Mental Health Act 1983, s.63.

70 1983 Act, s.56(1)(b).

71 *Hansard* (HC) vol. 490, cols. 379-382.

72 Consultation Paper No. 129.

73 1989 Act, s.45(10).

74 None of this would preclude an application for judicial review or habeas corpus.

Discharge of an emergency protection order

3.44 We do not believe that an emergency protection order should be able to continue for more than seven days. Of course, the order may be of a shorter duration if the court so directs. In proceedings under the Children Act 1989, there may be an application for a discharge of the emergency protection order after 72 hours of the making of the order.[75] The people who may apply are the child, any parent or person with parental responsibility for him and any person with whom he was living immediately before the order was made.[76] However, a person cannot apply if he was given notice of the hearing and was present at it.[77] In principle, of course, a party who wishes to challenge an order which was made *ex parte* has the right to apply to the court which made it to have it varied or discharged.[78] We believe that such a right should be provided in this case. Hence we provisionally propose that:

> **12. Where an emergency protection order is made *ex parte*, the person concerned, or someone acting on his behalf, or the person with whom he was living immediately before the order was made, should be able to apply to have it varied or discharged.**

Removal of abuser

3.45 Experience in other jurisdictions of the need to intervene to protect incapacitated adults has normally centred on the situation where the adult is living alone and has become incapable of self-care. In recent years, however, the problem of elder-abuse has achieved wider public recognition and is now seen as a greater threat to the dignity and welfare of the incapacitated adult than simple self-neglect. In recognition of this, and in accordance with the aim of enabling the incapacitated adult to remain in the community for as long as is practicable, several jurisdictions have accepted that in some circumstances the most

---

[75] Section 45(9).

[76] Section 45(9).

[77] Section 45(8).

[78] *WEA Records Ltd v. Channel 4 Ltd* [1983] 1 W.L.R. 721.

appropriate intervention will be to remove the abuser rather than the abused from the home. An example can be found in the Nova Scotian legislation.[79]

3.46 Until recently it was not thought that violence amongst elderly married couples was a significant problem. However, recent studies of elder-abuse have revealed that abuse by a spouse is at least as common as abuse by other carers.[80] Where the victim and the abuser are married to one another or living together as husband and wife, the victim can invoke the protection of the family law remedies for domestic violence and occupation of the family home. Other victims can only invoke the protection of the law of tort. These remedies are limited in their scope and effect and without the protection of the social services the victim may be unwilling to embark upon them.[81]

3.47 One possible solution might be to give the local social services authority power to assist an incapacitated, mentally disordered or vulnerable person to bring proceedings for a non-molestation or ouster order under the private law. This could be associated with a power, equivalent to that in the Children Act 1989,[82] to assist an abuser to find alternative accommodation. We invite views on these possibilities and also upon whether there is any scope in this area for additional powers along similar lines to those which we have recommended for the protection of children.[83] These would involve the possibility that, when making an emergency protection order, or perhaps also an assessment order, the court could add a condition that a person suspected of causing the incapacitated, mentally disordered or

---

[79] An Act to Provide for Protection of Adults from Abuse and Neglect 1985. Section 9 gives the court power to make a protective intervention order requiring any person who, in the opinion of the court, is a source of danger to the person in need of protection to leave the premises.

[80] C. McCreadie, *op. cit.* There is some doubt as to whether inter-spousal violence amongst the elderly should be classed as simple domestic violence and left to the private law or whether it should be classed as elder-abuse and thus fall under the public law.

[81] In our Report on Domestic Violence and Occupation of the Family Home, Law Com. No. 207 (1992), we proposed that the power to grant non-molestation orders should be extended to relatives and also to people sharing the same household, para. 3.26. We have also proposed that occupation orders, including ouster orders, should be available to applicants who are entitled to occupy the home against respondents who are associated with them in the same ways, para. 4.9.

[82] Children Act 1989, Sched. 2, para. 5.

[83] Law Com. No.207 (1992), paras. 6.15-6.22.

vulnerable person harm should leave the home for the duration of that order. If that condition were complied with, the supposed victim might then be left in the home, provided that there was some-one else there to look after him.

3.48 The object of this would be to enable the authorities to carry out their assessment without having to take the drastic and often damaging step of removing an incapacitated or vulnerable person from home. However, removing the carer from the home in this situation is likely to create further problems for social services and could only be a temporary solution. We also recognise that such powers are regarded by many as Draconian especially when the person whom it is sought to remove has occupation rights in the property from which he may be excluded. However, throughout this paper emphasis has been placed on the desirability of enabling incapacitated, mentally disordered or vulnerable people to live in the community for as long as possible, retaining control of their lives to the greatest extent possible compatible with the aim of providing protection for them.

Institutional abuse

3.49 The issue of abuse and neglect of adults in residential homes and other institutions has aroused heated debate in recent years. However, in the context of public authority powers and duties it raises few issues which require specific attention. We see no reason in principle why the new powers we believe a local authority should have could not be used to protect people living in private residential homes, nursing homes or mental nursing homes as well as their own or a carer's home. There are existing mechanisms for the registration of residential care homes,[84] nursing homes and mental nursing homes.[85] The Registered Homes Act 1984 and its associated Regulations also provide for the inspection of residential care homes,[86] nursing homes,[87] and mental nursing homes[88] by persons authorised by the Secretary of State and,

---

[84] Registered Homes Act 1984, Part I.

[85] *Ibid.*, Part II.

[86] 1984 Act, s.17(1) and (2).

[87] 1984 Act s.27(d) and Nursing Homes and Mental Nursing Homes Regulations, S.I. 1984, No. 1578, reg. 10.

in the case of residential care homes in its own area, authorised by a local social services authority. Where abuse or neglect of a resident in such accommodation is brought to the attention of the local authority this should trigger the operation of the duty to investigate which we have proposed at paragraph 3.14 above.

3.50 The point at which some difficulty may arise is the situation where the local authority are themselves responsible for providing accommodation to the person[89] who is alleged to be the victim of abuse or neglect.

Complaints under the 1990 Act

3.51 Section 50 of the 1990 Act, which inserts a new section 7B into the Local Authority Social Services Act 1970, gives the Secretary of State power to order a local authority to establish a procedure:

> "for considering any representations (including complaints) which are made to them by a qualifying individual, or *anyone acting on his behalf*, in relation to the discharge of, or any failure to discharge, any of their social services functions in respect of that individual" (emphasis added).

A qualifying individual is defined in section 7B(2) of the 1970 Act as:

---

[88] 1984 Act, s.35(1). Section 35(2) further provides that an inspector can interview in private any resident "who is or appears to be, suffering from mental disorder - (a) for the purpose of investigating any complaint as to his treatment made by or on behalf of the patient; or (b) in any case where the [inspector] has reasonable cause to believe that the patient is not receiving proper care...."

[89] See para. 2.7 above. Sections 42 - 45 of the National Health Service and Community Care Act 1990, provision of accommodation, amend the duties of local authorities under the National Assistance Act 1948 to provide accommodation to certain persons. Section 21 of the 1948 Act requires local authorities to make arrangements for providing residential accommodation for persons who by reasons of age, illness, disability or any other circumstances are in need of care and attention which is not otherwise available to them, and who are ordinarily resident in the local authority's area or are in urgent need. Accommodation provided under this section shall be managed by the local authority, or, by virtue of s.26 of the 1948 Act, by a voluntary organisation.

"any person for whom the local authority have a power or a duty to provide, or to secure the provision of, a service, and whose need or possible need for such a service has (by whatever means) come to the attention of the authority."

Such procedures[90] were to be established by 1 April 1991.[91]

3.52 The intention of the Act is to allow access to a statutory procedure to anyone who is likely to want to make representations, including complaints about the actions, decisions or apparent failings of the social services department; and to allow any other person to act on behalf of the individual concerned. The procedure excludes only those for whom the authority have no power or duty to provide a service, although anonymous complaints are also likely to fall outside the statutory definition.[92] Many otherwise incapacitated people should be able to authorise a person to complain on their behalf, as can somone who is merely vulnerable. However, we invite views on whether it would be desirable to clarify the circumstances in which a person can complain on behalf of someone who is so incapacitated as to be unable to authorise him to do so.

Advocacy

3.53 Sections 1 - 3 of the Disabled Persons (Services, Consultation and Representation) Act 1986 provide for the appointment of a person to represent the disabled person in his dealings with local authorities in relation to that person's need for services. These provisions of the Act have not been implemented. However, guidance issued to local authorities by the government urges them actively to encourage the establishment of advocacy schemes in their areas and to publicise the activities of such schemes in the information they publish on

---

[90] Department of Health, *Caring for People* (1990). Chapter 6 contains directions as to the setting up of a complaints procedure. The complaints procedure should (i) provide an effective means of allowing service users or their representatives to complain about the quality or nature of social services; (ii) ensure that complaints are acted upon; (iii) aim to resolve complaints quickly and as close to the point of service as possible; (iv) give those denied a service an accepted means of challenging the decision made; and (v) provide in defined circumstances for the independent review of a complaint.

[91] Local Authority Social Services (Complaints Procedure) Order 1990, S.I. 1990, No. 2244.

[92] Department of Health, *Caring for People* (1990), para. 6.5.

community care services.[93] Once again, however, the issue arises of whether an advocate can act on behalf of a person so incapacitated as to be unable to authorise him to do so and we invite views on this.

[93] Department of Health, *Care Management and Assessment: Managers' Guide* (1990), para. 2.53.

PART IV

GUARDIANSHIP

Introduction

4.1 Some mentally disordered patients may need close supervision and some control in the community either in their own interests or for the protection of other persons. Mental Health Act guardianship enables them to live in the community but grants a limited authority to the guardian to require them to do certain things. Although guardianship originated in the boarding-out arrangements made for mentally handicapped people, it was seen by the Percy Commission as a lesser version of compulsory powers to admit to hospital, and applicable to mentally ill and psychopathic patients as well as the mentally handicapped.[1]

4.2 A guardianship application may be made in respect of any person who has attained the age of 16 and who is suffering from specified forms of mental disorder[2] of such a nature or degree as to warrant reception into guardianship, where this is necessary in the interests of the welfare of the patient or for the protection of other persons.[3] People with mental handicaps can only be received into guardianship if they suffer from severe or significant impairment of intelligence and social functioning associated with abnormally aggressive behaviour or seriously irresponsible conduct.[4] An application for reception into guardianship can be made either by an approved social worker or by the nearest relative of the patient. In both cases the application is made to the local social services authority accompanied by the

---

1 Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency, Cmnd.169 (1957), para. 399.

2 Defined in s.7(2)(a) of the Mental Health Act 1983 as "mental illness, severe mental impairment, psychopathic disorder or mental impairment."

3 1983 Act, s.7(2). Section 37 allows for a guardianship order to be made in respect of mentally disordered offenders. While we are not examining the law in relation to mentally disordered offenders any reform of the existing guardianship powers could be applied to s.37 orders.

4 The conduct or behaviour need not be as a result of the handicap, simply associated with it: 1983 Act, s.1(2).

written recommendations of two registered medical practitioners.[5] The application must reach the local social services authority within 14 days of the second medical examination. It is ineffective unless accepted by the authority. There is no obligation on the social services authority to agree to be named as guardian or to accept the application on behalf of another person named as guardian.[6] Guardianship lasts initially for six months but may be renewed for a further six months and then for a year at a time.[7] The patient may apply to a Mental Health Review Tribunal once within each of these periods.[8]

4.3 In its *Fourth Biennial Report* the Mental Health Act Commission again expressed regret at the limited use of guardianship.[9] One reason for this appears to be the view that the powers available to the guardian are insufficient to exercise proper supervision over the patient. There has been a great deal of debate in recent years on whether the powers available to the guardian should be increased if guardianship is to prove a viable alternative to admission to hospital. The existing powers are limited to:

(a) requiring the patient to reside at a specified place;

(b) requiring the patient to attend at places and at times so specified for the purpose of medical treatment, occupation, education or training;

(c) requiring access to the patient to be given at any place where the patient is residing to any registered medical practitioner, approved social worker or other person specified by the guardian.[10]

---

5 The rules about the medical examinations, the doctor's qualifications and relationships with one another and with the other people involved are the same as those for compulsory admission to hospital.

6 1983 Act, s.7(5).

7 1983 Act, s.20(1).

8 See para. 4.17 below.

9 The Mental Health Act Commission *Fourth Biennial Report 1989-1991* (1991), para. 13.9.

10 1983 Act, s.8(1).

4.4 Commentators on the guardianship scheme have identified two major deficiencies in these powers. The first is the absence of a power to convey the client to the premises specified by the guardian.[11] The second relates to the inability of the guardian to consent to medical treatment on behalf of the patient or to require the patient to undergo medical treatment. In this paper we make no proposals as to consent to medical treatment as this is dealt with in the second Consultation Paper in this series.[12] The Royal College of Psychiatrists have recently recommended the introduction of a community supervision order for a very limited class of former hospital patients. If this is accepted, the relationship between the new order and guardianship would require careful consideration. There could be scope for combining the two in a new form of community supervision and treatment order (or reception).

4.5 The position in Scottish law is that guardianship can only be authorised by a competent legal authority. In Scotland, section 40 of the Mental Health (Scotland) Act 1984 requires that an application for guardianship must be submitted to the sheriff for approval within seven days of the later of the two medical examinations. Once the application has been submitted to the sheriff he may make such enquiries and hear such evidence as he thinks fit.[13]

Who may become guardian?

4.6 A guardian may be either the local authority or any other individual who is acceptable to the local authority. If our proposals for the appointment of personal and financial managers in "private law" proceedings[14] are accepted, we do not believe that there would be a need for the continuing possibility of a private individual becoming a Mental Health Act guardian. If it is necessary for someone to make decisions on behalf of an incapacitated person, we

---

[11] See para. 4.12 below.

[12] Mentally Incapacitated Adults and Decision-Making: Medical Treatment And Research (1993), Consultation Paper No. 129.

[13] Section 113 of the Mental Health (Scotland) Act 1984.

[14] See Consultation Paper No. 128, Parts V and VI.

believe that the best solution is to apply to the proposed new judicial forum for appointment as a personal manager. Therefore we provisionally propose that:

1. It should no longer be possible to appoint an individual as guardian under the Mental Health Act 1983.

4.7 This proposal would have little impact on guardianship as it currently operates. Of the 326 people subject to guardianship in only 14 cases is the guardian someone other than the local authority.[15] We have also sought to clarify the role of carers by proposing a statutory authority to do "what is reasonable in all the circumstances to care for that person and to safeguard and promote his or her personal welfare."[16] The existence of this authority may reduce the need felt by carers to apply for appointment as guardian.

4.8 This would mean that Mental Health Act guardianship would become an exclusively "public law" institution under the management of social services departments. Therefore we provisionally propose that:

2. Guardianship should continue to be administered by local social services authorities.

4.9 However, several of our respondents suggested that health authorities should be allowed to become guardians in addition to the local social services authority. We would welcome further comments on whether this would be desirable.

---

[15] Department of Health Statistics (Provisional).

[16] Consultation Paper No. 128, para. 2.13.

Powers of guardians

4.10 In the White Paper which preceded the Mental Health Act 1983,[17] three options were put forward to cater for the long term needs of mentally disordered people. These options were:

(a) to retain guardianship in its existing state but adding a power to consent to treatment;[18]

(b) to create community care orders; or

(c) to reduce guardianship powers to the minimum required, the 'essential powers' approach.

The Government eventually decided upon the 'essential powers' approach, which entailed that only the minimum powers necessary to secure the necessary care for the mentally disordered person would be granted.[19]

4.11 If guardianship is to be retained as a useful long term option then some reconsideration of the powers available to the guardian seems necessary. Such extension of the guardian's powers need not be incompatible with the principles set out in paragraph 1.15 above. We welcome comments on the range of powers which ought to be available to the local authority in exercising a guardianship role.

Power to convey

4.12 It has been noted for some time that the absence of a power to convey the client to the premises at which the guardian has specified the client must reside defeats the purpose

---

17 Reform of Mental Health Legislation, Cmnd. 8405, (1981).

18 Guardianship under the Mental Health Act 1959 gave the guardian all the rights and duties a father had in relation to his children under 14.

19 *Code of Practice*, para. 13.1, "the purpose of guardianship is to enable patients to receive care in the community where it cannot be provided without the use of compulsory powers. It enables the establishment of an authoritative framework for working with a patient with a minimum constraint to achieve as independent a life as possible within the community."

of the guardian having such a power. It is stated in the *Code of Practice* that guardianship is not to be used solely for the purpose of transferring an unwilling person into residential care.[20] Nevertheless, the provision of residential care may be part of the comprehensive care plan which the Code also advises should be devised for guardianship patients.[21] In many cases, a power to convey to the specified premises would only be used once, the client thereafter accepting the authority of the guardian. Accordingly we propose:

3. Local authority guardians should have power to convey a person received into guardianship to premises specified by them.

4.13 One commentator[22] has also noted that the lack of effective sanctions if a patient refuses to follow the instructions of the guardian makes a nonsense of the scheme. The same writer notes in respect of the compulsory powers, "...it is the very concept underlying guardianship, the use of compulsion outside the hospital which is flawed. Ultimately, the use of compulsion cannot be divorced from its institutional setting."[23] These are forceful arguments, in effect that guardianship is only a viable option when the patient does not actively resist the use of the guardian's powers. We are not convinced, however, that active resistance will be the most common reaction to the exercise of authority by guardians. Guardianship may be useful, not only where the patient refuses local authority attempts to help but also where a third party, for example a carer, obstructs the local authority. It may also have a role in clarifying the position of patients in their dealings with others.

Persons under guardianship

4.14 Under the Mental Health Act 1959 guardianship could be used in respect of people with a mental handicap as well as those who were mentally ill. In fact, guardianship was most often used for this group of people. However, during the passage of the 1983 Act in the

---

[20] *Ibid.*, para. 13.9.b.

[21] *Ibid.*, para. 13.4.

[22] M. Fisher, "Guardianship under the Mental Health Legislation: A Review" [1988] J.S.W.L. 316. 326.

[23] *Ibid.*, p.326.

House of Lords there was much concern expressed regarding the possible use of compulsory powers to detain and treat[24] those with a mental handicap.[25] It was thought that it would be wholly inappropriate and stigmatising to treat mentally handicapped people within the same structure as that designed for the mentally ill.[26] As a result, the definition of those in respect of whom long term powers in the Act could be exercised was changed so as to exclude the mentally handicapped unless their severe or significant impaired intelligence or social functioning was associated with abnormally aggressive or seriously irresponsible conduct.[27] This had the inevitable effect that most incapacitated people were excluded from those for whom guardianship can be used.

4.15 In a recent study of abuse of adults with a mental handicap many of the respondents to a questionnaire felt that use of guardianship would have helped resolve the problem of abuse.[28] The Mental Health (Scotland) Act 1984 allows for a guardianship application to be made in respect of a person, who is suffering from "mental disorder". Mental disorder includes both mental illness and mental handicap. A similar scheme is contained in the legislation in Northern Ireland.[29] If there were a case in Scotland or Northern Ireland which involved a person presenting the same condition as Beverley Lewis[30] guardianship would be a viable option. There does not seem to be any good reason why in this area the law of the various jurisdictions within the United Kingdom should differ.

4.16 There are two possible solutions to this problem. One is to expand Mental Health Act guardianship so as to include mentally incapacitated people. However, if this were to be done,

---

[24] Under what are now ss. 2-6 of the 1983 Act.

[25] Many organisations involved in caring for or representing the interests of the mentally disabled advocated the removal from mental health legislation of all mention of the mentally disabled. If the mentally disabled were to be subject to any of the powers in the Mental Health Act 1983 this would arise not because of their disability but because of an associated mental disorder.

[26] *Hansard* (H L), 1 December 1981, vol.425, col. 970.

[27] Mental Health Act 1983, s.1(2).

[28] L. B. Cooke, *op. cit.*, p. 608.

[29] Mental Health (Northern Ireland) Order 1984, S.I. 1984, No. 595.

[30] See para. 1.14, n.24 above.

there would also be a need for significant alterations in the present functions and powers of a Mental Health Act guardian. As we explain in Part V,[31] we see significant differences between that role and the role of a personal manager appointed under the new "private law" jurisdiction which we have already proposed.[32] That jurisdiction could be used for the appointment of local authorities as personal managers for incapacitated people. We also see significant advantages in keeping the two schemes separate. Mental Health Act guardianship would continue to be used as a structure for supervising and supporting in the community mentally disordered people who would otherwise have to be kept in hospital. A guardianship order under section 37 of the Act could also remain as a possible disposal in criminal proceedings. It involves an element of curtailing the rights of a mentally disordered person either for his own sake or for the protection of other people, which is appropriate for the people to whom it currently applies, but would not be appropriate for the incapacitated people with whom we are concerned in this project. Accordingly we provisionally propose:

4. Mental Health Act guardianship should not be extended to include the incapacitated.

Supervision of guardianship

4.17 There are two methods whereby reception into guardianship is monitored. In the first instance the responsible local social services' authority are required to arrange for every patient received into guardianship to be visited at such intervals as the authority may decide, but in any case at intervals of not more than three months and at least one such visit in any year shall be made by a practitioner approved under section 12 of the Act.[33] Similar provisions exist in Scotland. There is also a right of appeal to a Mental Health Review Tribunal.[34] On application by the patient (within six months of reception and once within

---

[31] See para. 5.2 below.

[32] Mentally Incapacitated Adults and Decision-Making: A New Jurisdiction (1993), Consultation Paper No. 128.

[33] The Mental Health (Hospital, Guardianship and Consent to Treatment) Regulations 1983, S.I. 1893, No. 893, r.13.

[34] 1983 Act, s.66.

each renewal period), the Tribunal has a general discretion to discharge a patient subject to guardianship. However, the Tribunal must discharge the patient if it is satisfied:

> (a) he is not then suffering from one of the four forms of mental disorder; or
> (b) it is not necessary in the interests of his welfare or for the protection of others that he should remain under guardianship.[35]

The local authority is under a duty to ensure that the patient is aware of the right to apply to a Mental Health Review Tribunal and is also obliged to ensure that a named officer will give any necessary guidance to the patient in the making of an application. We raise for consultation the possibility of requiring an automatic referral to the Mental Health Review Tribunal six months after reception into guardianship if the patient has not already made an application for discharge. Under the existing legislation a hospital manager is obliged to refer to a Mental Health Review Tribunal the case of anyone transferred from guardianship to hospital for admission for treatment.[36]

4.18 In Consultation Paper No. 128 we invited comments on whether the powers of the Mental Health Act Commission should be extended to those people for whom a personal manager has been appointed.[37] The case for such an extension is equally applicable to Mental Health Act guardianship. In its *Fourth Biennial Report 1989-1991*, the Mental Health Act Commission said that it was sometimes approached about a complaint relating to someone under Mental Health Act guardianship and observed that it would welcome an amendment to its statutory powers[38] to include within its remit those under guardianship.[39] Accordingly we provisionally propose that:

---

35 Section 72(4).

36 Section 68(1).

37 Consultation Paper No. 128, para. 6.25.

38 By virtue of s.121(2)(b) of the Mental Health Act 1983 and S.I. 1983, No. 892 the Secretary of State has directed the Mental Health Act commission to carry out the duties imposed upon him by s.120 of the 1983 Act.

39 Mental Health Act Commission *Fourth Biennial Report 1989-1991* para. 11.3(h).

5. **The powers of the Mental Health Act Commission should be extended to include persons who have been received into guardianship.**

PART V

LOCAL AUTHORITIES AND THE PROPOSED NEW JURISDICTION

Introduction

5.1 The object of this Part is to consider the use by public authorities of the new structure of personal orders, including the appointment of personal managers, which we have already proposed in our consultation paper on a new "private law" jurisdiction.[1] This also raises the question of its relationship with Mental Health Act guardianship. In this Part, we are only concerned with people who are incapacitated.[2] Where a person is vulnerable but neither incapacitated nor suffering from mental disorder of such a nature or degree as to warrant either his admission to hospital or his reception into guardianship under the Mental Health Act 1983, we see no justification for anyone to assume the power to make decisions on his behalf.

5.2 In relation to the incapacitated, one possibility is that the proposed new scheme should co-exist with Mental Health Act guardianship, each performing a different function. There is a fundamental distinction between the roles of a Mental Health Act guardian and a personal manager under the proposed new scheme. The duty of the personal manager is to take those decisions, acting in the best interests of the incapacitated person, which the incapacitated person is unable to take for himself. However, the incapacitated person would retain the right, under the presumption of competence, to take those decisions which he is able to take, whether or not the personal manager thinks those decisions are in the incapacitated person's best interests. This is quite different from the role of a Mental Health Act guardian. This is based, not on the incapacity of the client, and hence his inability to take certain decisions, but on the need to supervise his life in the community, either for his own protection or for the protection of others. Therefore, even though the client may have the capacity to take a

---

1 Consultation Paper No. 128.

2 We define the phrase 'incapacitated person' in Proposal 2 under paragraph 2.19 above.

decision, the guardian has the authority, in certain limited areas, to direct the client what to do. It would possible to retain and expand Mental Health Act guardianship so that it was available to perform this supervisory function for all incapacitated people, while allowing public authorities also to make use of the proposed new jurisdiction in those cases where it would be more appropriate to do so.

5.3 On the other hand, although a reformed guardianship scheme may well have a role in the longer term supervision of mentally disordered people living in the community, we are aware that amongst professionals in this field the inclusion of incapacitated people in a scheme which was principally designed as an alternative to hospital admission for the mentally ill causes some concern. For this reason we canvass here the possibility of adapting the new system of orders, which we have already recommended should be available to private individuals, for use by public authorities.[3] Guardianship would retain its present role of controlling the behaviour of certain mentally disordered clients,[4] while the new scheme would deal with those incapacitated clients who need a substitute decision-maker but for whom there is no private individual to fulfil this role. We invite views upon the following proposal:

1. **Mental Health Act guardianship should remain limited to the supervision in the community of certain mentally disordered patients. Where decisions have to be taken on behalf of incapacitated people, local authorities should make use of the new jurisdiction proposed in Consultation Paper No. 128.**

The new jurisdiction

5.4 We have already proposed in Consultation Paper No. 128 that a local authority should be able to apply under the new "private law" jurisdiction for a single issue order[5] or for an order appointing the Director of Social Services personal manager. Unlike the other powers

---

[3] We appreciate that this scheme bears a strong resemblance to that proposed by BASW, *op. cit.* (1990).

[4] Including its role in relation to mentally disordered offenders: see Mental Health Act 1983, s.37.

[5] See para. 5.5 below.

which have been discussed in this paper, this jurisdiction is limited to people who have been assessed as incapacitated.

Single issue orders

5.5 We have also recommended[6] that wherever possible an order dealing with a single issue, for example that the client has contact with a named person, should be preferred to an order appointing a person to make decisions on behalf of the incapacitated person over a wide range of issues. The specific orders which we have provisionally proposed should be available under the new jurisdiction are:

(i) An order settling the arrangements to be made as to where or with whom the incapacitated person is to live.
(ii) An order requiring the person with whom the person lives to allow that person to visit, stay with or otherwise have contact with another person.
(iii) An order restraining a person from having contact with, molesting or otherwise interfering with the incapacitated person.
(iv) An order dealing with a specific issue in relation to the care or welfare of the incapacitated person.

5.6 We see no difficulty in principle with public authorities being able to seek contact, non-molestation and specific issue orders on behalf of their incapacitated clients. Residence orders, however, raise rather different issues as they constitute a serious interference with the liberty of the incapacitated person. As such orders would have to be made by a judicial forum, the procedural safeguards would be at least as good as those for reception into Mental Health Act guardianship. Under the new statutory arrangements relating to children, it is not sufficient merely to say that it will be better for the child if an order is made placing him in the care of the local authority. Before such an order is made it is necessary to show that the child is suffering or likely to suffer significant harm, because he is not receiving the care

---

[6] Consultation Paper No. 128, para. 4.13, proposal 5.

which it would reasonable to expect a parent to give him.[7] Under our proposed scheme, the judicial forum would be guided solely by what was in the best interests of the incapacitated person, although it would also have to take into account certain other factors. The difference between children and incapacitated adults is that the law places upon parents the primary responsibility for looking after and bringing up their children. There are many reasons for this, including the importance attached in our society to the freedom of families to bring up their children as they wish.[8] Although, of course, the family has an important role in relation to its adult incapacitated members, the legal concept of an "extended minority" was decisively rejected by respondents to our overview consultation paper.[9] We see no reason in principle, therefore, why local authorities should not be able to apply for residence orders on the same basis as private individuals.[10]

5.7 A further question, however, is whether the right to apply for such orders should be limited to local social services authorities, or whether health authorities or even individual professionals working within those authorities should also be able to apply. In our consultation paper on the new jurisdiction, we provisionally proposed that only close relatives, carers and the incapacitated person himself should be able to apply as of right.[11] Other persons, including public authorities, would have to seek leave before doing so. We tend to the view that this is still the right approach for health authorities and individual professionals. However, we invite views upon whether this would pose difficulties for local social services authorities, particularly if Mental Health Act guardianship were not to be expanded to cover incapacitated people. We also invite views upon whether it would be appropriate to permit authorised social workers to make applications in their own right. Accordingly we provisionally propose that:

---

7 Children Act 1989, s.31(2).

8 See e.g., *Review of Child Care Law, op. cit.*, para. 2.13: "But 'the child is not the child of the state' and it is important in a free society to maintain the rich diversity of lifestyles which is secured by permitting families a large measure of autonomy in the way in which they bring up their children."

9 Consultation Paper No. 119.

10 See also Consultation Paper No. 128, para. 6.17, proposal 7.

11 *Ibid.*, para. 6.16.

2. **Health authorities and individual professionals should be permitted to seek leave to apply for an order under the proposed new jurisdiction. Social services authorities [or an officer authorised for this purpose] should be permitted to apply without leave.**

Personal management

5.8 We also proposed in Consultation Paper No. 128 that the judicial forum might appoint the Director of Social Services as personal manager of a client if there was no other suitable candidate.[12] We said that it would most often be appropriate for the local authority to use public law powers but noted that at times it might be suitable to invoke the private law.[13] We did not specify all the decisions which the personal manager would be authorised to take, although we listed the types of decisions covered by such schemes in other jurisdictions.[14] We did propose that the personal manager should be under a positive duty to take action in the incapacitated person's best interests.[15] We also proposed that the presumption of competence should continue to apply, even where a personal manager has been appointed.

5.9 We appreciate that the appointment of the Director of Social Services as personal manager might cause some practical problems. In practice, the role would be delegated to an individual social worker. It may be, however, that it would be inappropriate for that social worker to be the client's "care manager" for the purpose of devising a package of community care services for him. The care manager has to balance the needs of the individual client against the needs of others and the resources available to meet those needs. The "personal manager" under our proposed new scheme is expected always to act in the best interests of the individual incapacitated person. While it is not uncommon for different social workers

---

[12] *Ibid.*, para. 6.19, proposal 9.

[13] We said of the appointment of a personal manager that this should be a secondary option. In accordance with the principle of "least restrictive option" we proposed that as far as possible the judicial authority should seek to deal with the specific issue before it by way of a single order; see Consultation Paper No. 128, para. 4.13.

[14] Consultation Paper No. 128, para. 6.1.

[15] Taking into account the considerations set out in para. 5.13 below.

within the same authority to perform different roles in relation to the same client, we invite views upon whether this would cause particular difficulties within local social services departments. In any event, we remain of the view that a public authority should only be appointed personal manager where there is no other individual available to take the decisions which the client is himself incapable of taking. We do not think that the appointment of a personal manager is appropriate when the problem at issue is the need to control or supervise the client's behaviour in order to protect others from harm or serious nuisance.[16] We therefore provisionally propose that:

3. **The judicial forum may appoint the Director of Social Services for the appropriate local authority as personal manager for an incapacitated person if there is no other suitable candidate.**

Protecting property and financial management

5.10 Under section 48 of the National Assistance Act 1948, where a person is admitted as a patient to any hospital, or is admitted to Part III accommodation[17] or is removed pursuant to an order made under section 47 of the Act, and there is a danger of loss or damage to any movable property of his by reason of his temporary or permanent inability to protect or deal with the property and no other arrangements have been made for that purpose, the council[18] is under a duty to take reasonable steps to prevent or mitigate the loss or damage. For the purposes of fulfilling this duty the council has a power at all reasonable times to enter any premises which, immediately before the person's admission to hospital or Part III accommodation or removal, were his place of residence or usual place of residence. We agree with the underlying aim of this provision, that where a local authority seek to exercise a power to remove that they should be under a duty to preserve the property of the person

---

16 See also paras. 4.16 and 5.2 above.

17 I.e. residential accommodation provided by a local authority under Part III of the National Assistance Act 1948; see para. 2.7 above.

18 The council means in relation to any property, the council which is the local authority for the purposes of the Local Authority Social Services Act 1970 and in the area of which the property is for the time being situated, National Assistance Act 1948, s.48(4).

removed. Where a person is removed under an emergency protection or an assessment order,[19] the need to protect his property or administer his affairs should be adequately catered for by the duty imposed by section 48 of the 1948 Act. We invite views, however, on whether a local authority should be under a wider duty, whenever they remove or provide or arrange accommodation for an incapacitated person away from home, to take such steps as are reasonable to protect all that person's property and affairs. We provisionally propose that:

4. The local social services authority should have a duty to take such measures as are practicable to protect the property and affairs of those incapacitated people they remove or provide or arrange accommodation for away from home.

5.11 Under the Mental Health Act 1983[20] the jurisdiction of the Court of Protection can be invoked whenever the Court is satisfied that a person is incapacitated, by reason of mental disorder, of managing and administering his property and affairs. The Court exercises its functions in relation to the client by making such orders and giving such directions as it thinks fit. Alternatively the Court may appoint a Receiver to carry out the functions exercisable by the Court under sections 95 and 96 of the Mental Health Act.

5.12 In Consultation Paper No. 128 we made provisional proposals for reforming the functions of the Court of Protection and amalgamating them with the proposed new jurisdiction to make orders relating to personal care.[21] At present the intervention of the Court of Protection has the effect of suspending completely the client's ability to deal with his property and affairs. The appointment of a continuing financial manager, we argued, was appropriate only where resort to single issue orders was not practicable, as for example where the client has been rendered incapable of managing his affairs following an accident. We also thought that as far as possible the appointment of a financial manager should be of limited

---

[19] See Part III above.

[20] Mental Health Act 1983, ss.93 - 113.

[21] Consultation Paper No. 128, Part V.

duration. There are local authorities which already act as receivers for some of their incapacitated clients and we understand that the system works well. Therefore we provisionally propose that:

5. **The judicial forum may appoint the Director of Social Services for the appropriate local authority as financial manager for an incapacitated person.**

Principles

5.13 In making an order dealing with the specific issue or in appointing a personal manager, we also proposed that:

6. **Any order made by the judicial forum should be in the best interests of the incapacitated person, taking into account:**

   (a) **the ascertainable past and present wishes and feelings of the incapacitated person;**

   (b) **the need to encourage and permit the incapacitated person to participate in any decision-making to the fullest extent of which he is capable;**

   (c) **the general principle that the course least restrictive of the incapacitated person's freedom of decision and action is likely to be in his best interests.**[22]

5.14 We also proposed that those same principles should guide administrative bodies in their decisions relating to incapacitated people for whom they were responsible.[23] We

---

[22] Consultation Paper No. 128, para. 4.14.

[23] *Ibid.*, para. 4.5.

believe that this is especially applicable to the decisions of local social services authorities. Hence we invite further comments on the following:

7. **Where a decision is taken by a local social services authority on behalf of an incapacitated person, that body should have a duty to act in the best interests of the incapacitated person, taking into account:**

(1) the ascertainable past and present wishes and feelings of the incapacitated person;

(2) the need to encourage and permit the incapacitated person to participate in any decision-making to the fullest extent of which he is capable; and

(3) the general principle that the course least restrictive of the incapacitated person's freedom of decision and action is likely to be in his best interests.

PART VI

COLLECTED PROVISIONAL PROPOSALS AND CONSULTATION ISSUES

PART I - INTRODUCTION

We welcome suggestions for alternatives to the term "patient" (paragraph 1.17).

PART II - DEFINING THE CLIENT GROUP

Protective powers: the existing law

1. **Section 47 of the National Assistance Act 1948 and the National Assistance (Amendment) Act 1951 should be repealed and replaced by a new scheme giving clearer and more appropriate powers to local social services authorities to intervene to protect incapacitated, mentally disordered or vulnerable people (paragraph 2.10).**

Incapacitated people

2. **An incapacitated person is one who is either**

(a) **suffering from mental disorder within the meaning of the Mental Health Act 1983 and unable to understand an explanation in broad terms and simple language of the basic information relevant to taking the decision in question, including information about the reasonably foreseeable consequences of taking or not taking it, or unable to retain that information for long enough to take an effective decision; or**

(b) **unable by reason of his mental disorder to make a true choice in relation to that decision; or**

(c) **unable to communicate the decision in question to others who have made reasonable efforts [taken all practicable steps] to understand it (paragraph 2.19).**

The vulnerable

3. **A person is vulnerable if by reason of old age, infirmity or disability (including mental disorder within the meaning of the Mental Health Act 1983) he is unable to take care of himself or to protect himself from others (paragraph 2.29).**

The relevant age

4. **Public law powers should be available to protect incapacitated or mentally disordered or vulnerable people aged 16 and over (paragraph 2.30).**

PART III - INVESTIGATION, ASSESSMENT AND SHORT TERM INTERVENTION

For the purposes of investigating allegations of abuse and assessing a person's need for services we welcome comments on whether an integrated framework catering for all incapacitated, mentally disordered or vulnerable people should be created, or whether the Mental Health Act 1983 should be left to deal with mentally disordered people and a separate scheme established for the incapacitated and vulnerable (paragraph 3.2).

We welcome views on whether any or all of the remedies proposed below should be exercised, in cases where a person who is believed to be vulnerable but not incapacitated or mentally disordered, only where that person is believed not to object (paragraphs 1.16 and 2.29).

The responsible authority

1. **The local social services authority should be the agency responsible for investigating allegations of neglect or abuse of an incapacitated, mentally disordered or vulnerable person (paragraph 3.11).**

We invite views on whether a district health authority, or an officer authorised by that authority, in addition to the local social services authority, should be able to initiate the procedures recommended below (paragraph 3.12).

2. **The local social services authority should be responsible for initiating proceedings in relation to the care and protection of incapacitated, mentally disordered or vulnerable people (paragraph 3.12).**

Investigation of neglect and abuse

3. **Where a local authority have reasonable cause to suspect that a person is incapacitated, mentally disordered or vulnerable and is suffering or is likely to suffer significant harm [or serious exploitation], they should be under a duty to make such enquiries as they reasonably can, including taking steps to gain access to that person, and to decide whether they should take any action to provide community care services for that person or otherwise protect him from harm [or exploitation] (paragraph 3.16).**

We invite comments on whether or not it would be appropriate for there to be guidance on suitable case conference procedures, equivalent or similar to those now in use for the protection of children, when a local authority are considering the exercise of compulsory powers in respect of an incapacitated or mentally disordered or vulnerable person (paragraph 3.20).

We welcome views on the desirability of setting up registers of those incapacitated, mentally disordered or vulnerable people about whom the local authority are

concerned because they may not be receiving adequate care or they may be being abused (paragraph 3.22).

Powers of entry and rights of access

4. **An officer of the local social services authority, authorised for this purpose, should have power to enter premises where any person believed to be incapacitated, mentally disordered or vulnerable is living, if there is reasonable cause to suspect that that person is suffering, or is likely to suffer, significant harm [or serious exploitation] (paragraph 3.25).**

Refusal of access

5. **It should be an offence (equivalent to that in section 129(1) of the Mental Health Act 1983), without reasonable cause, to refuse to allow an authorised person to enter and inspect premises, or to have access to the person believed to be at risk, or otherwise to obstruct the exercise of the powers provided for in proposal 4 above (paragraph 3.26).**

Entry warrants

6. **An officer of the local social services authority, authorised for this purpose, should be able to apply for a warrant authorising a constable, accompanied by that officer, to enter any premises, by force if necessary, where there is reason to believe that a person who is believed to be incapacitated, mentally disordered or vulnerable, is suffering or is likely to suffer significant harm [or serious exploitation] [and, in the case of a vulnerable person, that he would not object to such entry being gained on this occasion] (paragraph 3.30).**

Examination and assessment

7. **The local social services authority should be able to apply for an order of limited duration authorising them to carry out an assessment of the capacity and needs, either for protection or for community care services or both, of any person they have reasonable grounds to believe is incapacitated or mentally disordered or vulnerable and is suffering or is likely to suffer significant harm [or serious exploitation] and, in the case of a vulnerable person, that he would not object to the order being made (paragraph 3.34).**

We welcome comments on whether the assessment order should be able to include a power to examine and to which of the client groups such a power should apply (paragraph 3.35).

Emergency protection order

8. **The local social services authority [or an officer authorised for this purpose] should be able to apply for an emergency protection order authorising them to remove to a place of safety a person believed to be incapacitated or mentally disordered or vulnerable where there are reasonable grounds to believe that that person is likely to suffer significant harm [or serious exploitation] if not removed and, in the case of a vulnerable person, that he would not object to the order being made (paragraph 3.37).**

9. **Applications for an emergency protection order may be made *ex parte* if need be (paragraph 3.38).**

Duration

10. **A person who is taken to a place of safety under the power proposed above may be kept there for a maximum period of seven days (paragraph 3.39).**

We invite views as to whether a period shorter than seven days would be more appropriate (paragraph 3.39).

Duty to return home

11. **Where a person has been removed from home under an emergency protection order, the local social services authority should have a duty to return him as soon as it appears to them that he will not be at risk if this is done (paragraph 3.41).**

Appeal against an emergency protection order

We welcome comments on whether it should be possible to appeal against the making or the refusal to make an emergency protection order (paragraph 3.43).

Discharge of an emergency protection order

12. **Where an emergency protection order is made *ex parte*, the person concerned, or someone acting on his behalf, or the person with whom he was living immediately before the order was made, should be able to apply to have it varied or discharged (paragraph 3.44).**

Removal of abuser

We invite views on whether local social services authorities should have power to assist an incapacitated, mentally disordered or vulnerable person to bring proceedings for a non-molestation order or ouster order under the private law (paragraph 3.47).

We invite comment on whether such a power to assist in bringing proceedings under the private law could be associated with a power, equivalent to that in the Children Act 1989, to assist the abuser to find alternative accommodation (paragraph 3.47).

We also invite views on whether it should be possible for the court, when making an emergency protection order, or perhaps also an assessment order, to add a requirement that a person suspected of causing the incapacitated, mentally disordered or vulnerable person harm should leave the home for the duration of that order (paragraph 3.47).

Complaints under the 1990 Act

We invite views on whether it would be desirable to clarify the circumstance in which a person can complain on behalf of someone who is so incapacitated as to be unable to authorise him to do so (paragraph 3.52).

Advocacy

We invite views on whether an advocate can act on behalf of a person who is so incapacitated as to be unable to authorise him to do so (paragraph 3.53).

PART IV - MENTAL HEALTH ACT GUARDIANSHIP

Who may become guardian?

1. **It should no longer be possible to appoint an individual as guardian under the Mental Health Act 1983 (paragraph 4.6).**

2. **Guardianship should continue to be administered by local social services authorities (paragraph 4.8).**

We welcome comments on whether health authorities should be able to become guardians under the Mental Health Act 1983 (paragraph 4.9).

Power to convey

We welcome comments on the range of powers which ought to be available to the local authority in exercising a guardianship role (paragraph 4.11).

3. **Local authority guardians should have power to convey a person received into guardianship to premises specified by them (paragraph 4.12).**

Persons under guardianship

4. **Mental Health Act guardianship should not be extended to include the incapacitated (paragraph 4.16).**

Supervision of guardianship

We invite comments on whether there should be an automatic referral to the Mental Health Review Tribunal of all clients received into guardianship (paragraph 4.17).

5. **The powers of the Mental Health Act Commission should be extended to include persons who have been received into guardianship (paragraph 4.18).**

PART V - LOCAL AUTHORITIES AND THE PROPOSED NEW JURISDICTION

Introduction

1. **Mental Health Act guardianship should remain limited to the supervision in the community of certain mentally disordered patients. Where decisions have to be taken on behalf of incapacitated people, local authorities should make use of the new jurisdiction proposed in Consultation Paper No. 128 (paragraph 5.3).**

Single issue orders

We invite views on whether allowing health authorities and others to apply, with leave, to the judicial forum for a single issue order would pose difficulties for local social services authorities if guardianship under the Mental Health Act 1983 were not to be extended to include the incapacitated (paragraph 5.7).

2. **Health authorities and individual professionals should be permitted to seek leave to apply for an order under the proposed new jurisdiction. Social services authorities [or an officer authorised for this purpose] should be permitted to apply without leave (paragraph 5.7).**

We invite comment on whether it would be appropriate to permit authorised officers of the local authority to make applications for single issue orders in their own right (paragraph 5.7).

Personal management

In view of the need for a personal manager appointed under the new jurisdiction always to act in the best interests of the incapacitated person we would welcome comments on whether the appointment of the Director of Social Services as personal manager of an incapacitated person would cause problems for local social services authorities in light of their need to balance the needs of the individual client against the needs of others and the resources available to meet those needs (paragraph 5.9).

3. **The judicial forum may appoint the Director of Social Services for the appropriate local authority as personal manager for an incapacitated person if there is no other suitable candidate (paragraph 5.9).**

Protecting property and financial management

4. **The local social services authority should have a duty to take such measures as are practicable to protect the property and affairs of those incapacitated people they remove or provide or arrange accommodation for away from home (paragraph 5.10).**

5. **The judicial forum may appoint the Director of Social Services for the appropriate local authority as financial manager for an incapacitated person (paragraph 5.12).**

Principles

In making an order dealing with the specific issue or in appointing a personal manager we proposed in Consultation Paper No. 128 that:

6. **Any order made by the judicial forum should be in the best interests of the incapacitated person, taking into account:**

(a) the ascertainable past and present wishes and feelings of the incapacitated person;

(b) the need to encourage and permit the incapacitated person to participate in any decision-making to the fullest extent of which he is capable;

(c) the general principle that the course least restrictive of the incapacitated person's freedom of decision and action is likely to be in his best interests (paragraph 5.13).

We also proposed that the same principles should apply when administrative bodies take decisions relating to incapacitated persons for whom they are responsible.

7. Where a decision is taken by a local social services authority on behalf of an incapacitated person, that body should have a duty to act in the best interests of the incapacitated person, taking into account:

(1) the ascertainable past and present wishes and feelings of the incapacitated person;

(2) the need to encourage and permit the incapacitated person to participate in any decision-making to the fullest extent of which he is capable; and

(3) the general principle that the course least restrictive of the incapacitated person's freedom of decision and action is likely to be in his best interests (paragraph 5.14).

Resource implications of our proposals

We welcome comments on whether the proposals contained in this paper will have major resource implications for local authorities (paragraph 1.7).

APPENDIX

Jurisdiction and Judicial Remedies

1. The three Consultation Papers now published in this series make a number of proposals in relation to the three separate areas covered which, as we said in the first paper of the series, could either be combined into a single overall framework or implemented separately.[1] Part I of this appendix summarises the remedies which we have provisionally proposed should be available in a judicial forum of some kind. This may indicate how these proposals in the three papers might link with each other.

2. We would also welcome views on the type of judicial forum before which all or any of these remedies should be available. We therefore set out in Part II of the appendix a brief summary of the main options which we have identified and invite comment.

PART I

Summary of remedies proposed in Consultation Papers Nos. 128, 129 and 130

3. We propose that four different types of remedy should be available before a judicial forum of some kind. Some remedies are applicable to all kinds of decision, whether relating to a person's property and affairs, personal care and welfare, or medical treatment or research. Others apply only to one such area, principally medical treatment. For the purpose of summarising the proposed remedies, we have collected all these together. In Part II, however, we canvass views on whether it would be appropriate for the jurisdiction to be divided between different judicial fora according to the subject-matter.

---

[1] Consultation Paper No. 128, para. 1.3.

A declaratory jurisdiction

4. We propose that a judicial forum should have power to make a declaration:

(a) as to whether or not a person is currently incapacitated either in general or in relation to a particular matter (128 VI 4) (129 IV 8);

(b) as to whether or not a person has capacity to execute an enduring power of attorney within a specified time (128 V 18);

(c) as to whether or not an incapacitated person's anticipatory decision in relation to medical treatment is "clearly established" and "applicable in the circumstances" (129 IV 9).

A substitute decision-making jurisdiction

5. We propose that a judicial forum should have power to provide for decisions to be made on behalf of an incapacitated person aged 16 or more in two different ways:

(a) by deciding the issue itself in a single issue order doing any or all of the following:

(i) settling the arrangements as to where or with whom the incapacitated person is to live;
(ii) requiring the person with whom the incapacitated person lives to allow that person to visit, stay with or otherwise have contact with another person;
(iii) restraining a person from having contact with, molesting or otherwise interfering with the incapacitated person;
(iv) dealing with a specific issue in relation to the care or welfare of the incapacitated person (128 VI 1);
(v) dealing with a specific issue in relation to the management of an incapacitated person's property and affairs (128 V 17);

(vi) giving or withholding approval to particular medical treatments (129 IV 5);

(vii) requiring the person responsible for medical care to allow some other person to take over that care (129 IV 7).

(b) by appointing a *financial manager* or a *personal manager* or a *medical treatment proxy* (or the same person as all three) to take some or all of these decisions on the incapacitated person's behalf (128 V 13) (128 VI 2) (129 IV 10).

6. The forum should also have power to make recommendations as well as or instead of making an order (128 VI 5) (129 IV 6).

Jurisdiction over enduring powers of attorney

7. We propose that it should be possible to execute enduring powers of attorney covering decisions relating to personal welfare and/or medical treatment and/or financial matters (128 VII 1) (129 V 1). In addition to the power to declare that a person has capacity to do this, a judicial forum should have power to:

(a) cure technical defects in the execution of an EPA;

(b) appoint a replacement for an attorney who is unable to act;

(c) where the donor has so directed, modify or extend the powers granted;

(d) supervise the conduct of attorneys;

(e) revoke an appointment and make a substitute order (128 VII 14-15) (129 V 18-19).

A protective jurisdiction

8. We propose that in relation to a person believed to be incapacitated, mentally disordered or vulnerable and suffering or likely to suffer significant harm [or serious exploitation] (and in the case of person who is merely thought vulnerable if it is believed that he would not object) a judicial forum should be able to:

(a) issue a warrant authorising a police officer to gain entry to premises (130 III 6);

(b) make an order authorising an assessment of that person's capacity and needs for services or protection (130 III 7);

(c) authorising the removal of that person to a place of safety (for a maximum of 7 days) (130 III 8).

PART II

The judicial forum

A summary of the options

9. There are three main options for a new or reformed jurisdiction dealing with these questions: first, that the jurisdiction be fitted into the existing court structure; secondly, that specialist tribunals be created; and thirdly that the jurisdiction be divided between the courts and tribunals. Respondents to our overview consultation paper[2] emphasised the need for any jurisdiction to be local and accessible, informal and user-friendly, and to be able to deal with personal and financial matters together.

Courts

The present position

10. At present such jurisdiction as exists is divided up between various levels of court. The Court of Protection has a specialist jurisdiction in relation to the financial affairs of the mentally incapacitated but it can refer complex matters to the Chancery Division of the High Court. Enduring powers of attorney are restricted to financial matters and the Court of Protection has jurisdiction to regulate the scheme. Many of the serious medical treatment cases described in Consultation Paper No. 129 have been dealt with in the High Court by way of declaration proceedings while the public law powers described in Consultation Paper No.

---

[2] Consulation Paper No. 119.

130 are exercised in magistrates' courts. County courts currently have a minimal jurisdiction in relation to the "nearest relative" provisions of the Mental Health Act 1983. We do not consider that such an inefficient and costly fragmentation of jurisdiction is satisfactory.

An integrated jurisdiction

11. The Children Act 1989 heralded a new approach to jurisdiction for cases involving children. Concurrent jurisdiction under the Act is given to the High Court, county courts and magistrates' family proceedings courts and cases may be transferred between the different levels of court. A similar technique could be introduced in proposals for legislation dealing with incapacitated adults (and the protection of other mentally disordered or vulnerable adults) enabling all the issues in a single case to be determined in one forum by judges or magistrates with specialist training. The proposed protective or "public law" powers are such that they should, in principle, be exercised by a court rather than a tribunal. In such a system, there might still be limitations upon the powers of the magistrates' courts, particularly in relation to matters of finance. District judges in particular might have an important role in such a jurisdiction. The Court of Protection might be integrated into the system and at the High Court level the Family Division and Chancery Divison might have concurrent jurisdiction, as they do now, for example in relation to family provision.

Tribunals

The present position

12. Mental Health Review Tribunals are convened to consider whether patients detained or subject to guardianship under the Mental Health Act 1983 should be discharged. Tribunals sit at the hospital where the patient is detained. The tribunal president is legally qualified and sits with both a medical and a lay member. Assistance by way of representation is available under the legal aid scheme. Since the expansion of their jurisdiction under the Mental Health Act 1983, MHRTs have been under considerable pressure and delays have been a problem. Expanding their jurisdiction to deal with questions relating to incapacitated people (usually living in the community) might create further administrative problems and raise difficult

questions as to the venue for hearings and the qualifications appropriate for tribunal members.

New "incapacity" tribunals

13. Tribunals have the merits of accessibility, informality and a specialist membership which were urged upon us by our respondents. A new tribunal structure might be created to deal with the majority of the jurisdiction proposed and it could be linked, at least at the appellate level, with the ordinary court structure. However, it would not be appropriate for a tribunal to issue entry warrants or emergency protection orders authorising removal from home; nor would a tribunal specially constituted to make decisions about personal matters or medical treatment necessarily be qualified to make decisions about complex financial matters.

A mixed system

14. In our paper on medical treatment and research[3], we explained that we did not consider that the judicial forum which deals with medical decisions should necessarily be the same as that dealing with all the other matters with which these proposals are concerned. It would be possible to establish a separate machinery for those decisions, while leaving the others to be dealt with in the ordinary courts, perhaps by way of an integrated specialist jurisdiction along similar lines to that established under the Children Act 1989.

---

[3] Consultation Paper No. 129, para. 4.6.

Printed in the United Kingdom for HMSO.
Dd.294473, 5/93, C22, 3397/5, 5673, 241754.

ABOUT HMSO'S STANDING ORDER SERVICE

The Standing Order service, open to all HMSO account holders*, allows customers to receive automatically the publications they require in a specified subject area, thereby saving them the time, trouble and expense of placing individual orders.

Customers may choose from over 4,000 classifications arranged in more than 250 sub groups under 30 major subject areas. These classifications enable customers to choose from a wide range of subjects those publications which are of special interest to them. This is a particularly valuable service for the specialist library or research body. All publications will be despatched to arrive immediately after publication date. A special leaflet describing the service in detail and listing the main subject headings available may be obtained on request.

Write to PC11C, Standing Order Service, HMSO Books, PO Box 276, LONDON SW8 5DT quoting classification reference 1801015 to order future titles in this series.

* Details of requirements to open an account can be obtained from PC32A, HMSO Books, PO Box 276, LONDON W8 5DT.

HMSO publications are available from:

HMSO Publications Centre
(Mail, fax and telephone orders only)
PO Box 276, London, SW8 5DT
Telephone orders 071-873 9090
General enquiries 071-873 0011
(queuing system in operation for both numbers)
Fax orders 071-873 8200

HMSO Bookshops
49 High Holborn, London, WC1V 6HB
(counter service only)
071-873 0011 Fax 071-873 8200
258 Broad Street, Birmingham, B1 2HE
021-643 3740 Fax 021-643 6510
Southey House, 33 Wine Street, Bristol, BS1 2BQ
0272 264306 Fax 0272 294515
9-21 Princess Street, Manchester, M60 8AS
061-834 7201 Fax 061-833 0634
16 Arthur Street, Belfast, BT1 4GD
0232 238451 Fax 0232 235401
71 Lothian Road, Edinburgh, EH3 9AZ
031-228 4181 Fax 031-229 2734

HMSO's Accredited Agents
(see Yellow Pages)

and through good booksellers

£7.95 net

ISBN 0-11-730213-9

9 780117 302136