

The Draft Mental Incapacity Bill

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I. Introduction

'It is widely recognised that, in this area, the law as it now stands is unsystematic and full of glaring gaps'. (Mental Incapacity, Law Commission, 1995)¹

Despite the general agreement with the Law Commission's assessment of the failings of the current system for decision-making on behalf of people who lack the capacity to make decisions for themselves, the steps towards achieving comprehensive reform, as recommended in its report, *Mental Incapacity*, has been a protracted process. *Mental Incapacity* was followed, two years later, by a consultation paper – *Who Decides? Making Decisions on Behalf of Mentally Incapacitated People*² – in which the Government sought views on the Law Commission's recommendations for reform. In October 1999, the Lord Chancellor's Department published *Making Decisions*³, which set out the Government's proposal for reform, 'in the light of the responses to the consultation paper *Who Decides*'.

No clear timescale was given for the reforms, with *Making Decisions* stating that they could only be taken forward 'when Parliamentary time allows'. However, in June of last year the reform process moved to a significant stage with the publication of the Government's draft Mental Incapacity Bill ('the Draft Bill'). This set out proposals to reform the law:

*'in order to improve and clarify the decision making process for those aged 16 and over who are unable to make decisions for themselves.'*⁴

Thus provisions set out in the Draft Bill are based on the Law Commission's recommendations. However, not all the recommendations included in *Mental Incapacity* have been followed. For example, the Government decided not to take forward the proposals relating to the public law protection of vulnerable people.

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1 Law Com 231, March 1995

2 Cm 3803, Lord Chancellor's Department, December 1997

3 Cm 4465, *Making Decisions – The Government's proposals for making decisions on behalf of mentally*

incapacitated adults – A report issued in the light of responses to the consultation paper Who Decides?, October 1999

4 *Draft Mental Incapacity Bill, Commentary and Explanatory Notes – Making Decisions*, Department for Constitutional Affairs, June 2003, page 6

The Draft Bill was considered by the Joint Committee on the Draft Mental Incapacity Bill (the Joint Committee) which published its report in November 2003⁵. The Joint Committee stressed the enormity of the task it was expected to meet – in just over two months, providing detailed scrutiny of a draft Bill which was ‘*the product of an extensive consultation stretching back to 1989*’. Despite making nearly one hundred recommendations in relation to the Draft Bill, the Joint Committee concluded that there is a clear need for the Bill and supported, ‘*on the whole*’, the principles and general direction of the draft Bill. The recommendations include the need for guiding principles to be set out in the Bill⁶; greater clarity in relation to the scope of powers under the Bill⁷; the grey areas between the draft Bill and the present Mental Health Act 1983 (particularly the ‘Bournewood gap’⁸) to be addressed⁹ and the title of the Bill to be changed to ‘the Mental Capacity Bill’ to reflect more accurately the purpose of the Bill which is to recognise and give effect to the right to make decisions and remove the pejorative associated with incapacity¹⁰.

While acknowledging the amount of work involved in addressing their recommendations, the Joint Committee expressed their hope that the new Bill would soon be brought to Parliament:

‘...we would be extremely disappointed if the Government felt unable to continue to give the Bill priority. Those it is intended to help have waited long enough for the benefits it should bring them’¹¹.

2. Overview of the Proposals

The Draft Bill includes both informal and formal mechanisms for making decisions on behalf of people who lack capacity to make such decisions for themselves:

‘The Bill introduces new decision making mechanisms to allow welfare and healthcare decisions, as well as financial decisions, to be taken on behalf of persons lacking capacity. It begins by setting out a number of key principles and ways in which informal decisions can be lawfully taken on behalf of adults who lack capacity. As these principles are based on existing best practice for the majority of caring decision makers they will bring about no change in how they approach decision making. The Bill then lays out formal decision making powers that can be acquired or granted.’¹²

The main provisions of the Draft Bill cover the following areas:

- (In)capacity
- Best interests
- Informal decision-making: the General Authority
- Formal decision-making mechanisms: the Lasting Power of Attorney, new Court of Protection, Court appointed Deputies and Advance Decisions to Refuse Treatments

The Draft Bill sets out a range of decisions that cannot be made on behalf of others. These include consent to marriage, consent to have sexual relations and a decision on voting at an election for any public office.

5 *House of Lords, House of Commons Joint Committee on the Draft Mental Incapacity Bill, Draft Mental Incapacity Bill, Session 2002–03, HL Paper 189-1, HC 1083-1. This article was submitted prior to the publication of the Joint Committee’s report and therefore does not include a detailed analysis of the report.*

6 Paragraph 44

7 *See for example paragraphs 129, 132, 144 and 184*

8 *This is discussed below, see section 3.*

9 *See paragraphs 222, 225 and 227*

10 *Paragraph 365*

11 *Paragraph 23*

12 *Explanatory Note, page 6*

a. (In)capacity

The Draft Bill adopts a ‘functional’ approach to capacity in that an individual’s capacity will be assessed in relation to each decision that needs to be taken. Clause 1 states that a person lacks capacity in relation to a matter if:

‘at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of or a disturbance in the functioning of the mind or brain’

Thus the Draft Bill has removed the ‘diagnostic threshold’ favoured by the Law Commission, which recommended:

‘a new test of capacity should require that a person’s inability to arrive at a decision should be linked to the existence of a “mental disability”¹³.

The term ‘mental disability’ was defined as ‘a disability or disorder of the mind or brain, whether permanent or temporary, which results in an impairment or disturbance of mental functioning.’¹⁴ The Law Commission considered that using such a diagnostic threshold would provide protection to individuals by ensuring that the test does not include people who make unusual or unwise decisions¹⁵. However, the decision to remove ‘mental disability’ from the definition has been welcomed by the Making Decisions Alliance (MDA) – a consortium of 28 organisations campaigning for the introduction of mental incapacity legislation. The MDA has a number of concerns with this term, including that it ‘would risk stigmatising or prejudicing people who need support with decision-making¹⁶’.

The ‘impairment’ or ‘disturbance’ can be permanent or temporary. Furthermore, individuals are assumed to have the capacity to make their own decisions unless it is established otherwise.

The Draft Bill sets out the test for capacity, stating that individuals will be regarded as unable to make a decision if they are unable:

- to understand the information relevant to the decision,
- to retain the information relevant to the decision
- to use the information relevant to the decision as part of the process of making the decision, or
- to communicate the decision (whether by talking, using sign language or any other means).

Assessment of Capacity

Although the assessment on whether a person has, or lacks capacity, is key to the proposed legislation, the process of assessing capacity is not included in the Draft Bill. This omission is considered to be a major gap by the Mental Health Foundation (MHF) given the potentially far reaching and significant consequences of a finding of ‘incapacity’ – a concern shared by the MDA¹⁷. The MHF acknowledges that it will not be possible to set out detailed provision for the procedures for assessing capacity given that such assessments will be required in relation to a wide

13 Paragraph 3.12

14 Clause 2(2) of the Law Commission’s Mental Incapacity Bill

15 Paragraph 3.8

16 Paragraph 4.2 Submission to the Joint Committee on the Draft Mental Incapacity Bill, Making Decisions Alliance www.makingdecisions.org.uk

17 See 5d, page 26 of the Making Decisions Alliance’s submission. The MHF is a member of the Alliance.

range of personal welfare, health and financial matters and in many cases, where the general authority applies, a formal assessment process will be both impracticable and inappropriate. However, the MHF considers that some legal requirements are necessary, for example the MHF suggests:

‘...the Draft Bill should provide that a particular agency is given the responsibility for ensuring that the assessments of capacity are undertaken appropriately, for example by professionals with the relevant skills and experience.’¹⁸

In considering the assessment of an individual’s capacity to make a particular decision the Joint Committee commented that whoever assesses capacity must be prepared to justify their findings and if this gives rise to a dispute it will be a question for the Court of Protection to decide. The Joint Committee concluded that given the diverse range of situations covered by the proposed statutory framework for decision-making the processes and requirements relating to assessment of capacity would be better dealt with in the Codes of Practice¹⁹.

b. Best Interests

Anything done for, and any decision made on behalf of, a person without capacity under this legislation should be done or made in the ‘best interests’ of that person. The Explanatory Note to the Bill states:

‘The concept of acting in the best interests of a person who lacks capacity already exists in the common law. The Bill will enshrine this principle in statute as the overriding principle that must guide all decisions made on behalf of someone lacking capacity.’²⁰

The Draft Bill sets out a checklist of factors which those making decisions are expected to ‘work their way through when considering what is in the best interests of the person concerned’²¹. The matters to be considered include:

- whether the person is likely to have capacity in relation to the matter in question in the future;
- the need to permit and encourage the person to participate, or to improve his ability to participate, as fully as possible in any act done for and any decision affecting him;
- ‘so far as ascertainable’, the person’s past and present wishes and feelings.

If it is practicable and appropriate, the following individuals should be consulted about the person’s past and present wishes and feelings as well as the factors the person would consider if he or she were able to do so:

- anyone named by the person concerned as someone to be consulted on the particular issue
- any person engaged in caring for the person concerned or is interested in the person’s welfare
- any donee of a lasting power of attorney (see below) granted by the person concerned

18 *Draft Mental Incapacity Bill – Memorandum to the Joint Committee from the Mental Health Foundation and the The Foundation for People with Learning Disabilities, paragraph 4.6*

20 *Draft Mental Incapacity Bill, Commentary and Explanatory Notes – Making Decisions, Department for Constitutional Affairs, June 2003, page 7*

21 *ibid*

19 *Joint Committee, paragraphs 244 and 245*

- any deputy appointed by the court (see below)

The Draft Bill states that consideration must also be given to whether the purpose for which any act or decision is needed can be as effectively achieved in a way which is less restrictive of the person's freedom of action.

Best Interests and Advocacy

In determining what is in the best interests of the individual, it is vital that the focus is on the wishes and feelings of the person concerned, not what the consultees think the person concerned should think and feel. This is an area in which it will be crucial for individuals to be supported by advocates so that they can participate 'as fully as possible' in decisions affecting them.

Despite the important role that advocates have the potential to play in the implementation of the mental incapacity legislation (such as assisting those whose capacity is being assessed and supporting the participation of individuals in the decision making process) advocacy is not referred to in the Draft Bill. The MDA has called for the legislation to include a 'right to access to independent advocacy when formal powers are applied for' and a duty on the relevant Secretary of State 'to provide sufficient advocacy services to deliver this'²².

The Joint Committee agreed that independent advocacy services play an essential role in assisting people who lack capacity. However, the Joint Committee felt that it would be inappropriate to recommend that resources be committed to provide a statutory right to advocacy and therefore recommended that provisions of the Bill should empower the relevant Ministers to arrange:

'to such extent as considered necessary to meet all reasonable requirements, for the provision of independent advocacy services to incapacitated adults affected by the Bill's provisions'.²³

c. Informal decision making: the General Authority

Clause 6 provides for the 'general authority'. This is a key provision of the Draft Bill. It permits a person to 'do an act when providing any form of care for another person' where the person providing the care reasonably believes the other person lacks capacity in relation to the matter in question and 'in all the circumstances it is reasonable for the person to do the act'.

The intention of the general authority is to:

*'make lawful many day-to-day decisions that have to be made about the care and welfare of adults who lack capacity without the need for informal powers. It aims to clarify the principle of necessity that currently exists at common law.'*²⁴

The scope of the general authority is far too broad. For example, whereas the Law Commission's Mental Incapacity Bill included specific restrictions on the use of the general authority in relation to medical interventions (such as treatment for mental disorder) there are no similar provisions in the Draft Bill. Furthermore, the general authority permits the use of force and the restriction of a person's liberty of movement (whether the person resists or not) if it is believed that such action is necessary in order to avert a substantial risk of significant harm to the person without capacity. (Similar powers are given to the donee of a LPA.) No further details are provided in the Draft Bill

²² See paragraph 2.8 and also section 5b of the Making Decisions Alliance submission.

²³ Paragraph 302

²⁴ Explanatory Notes, paragraph 33

on how such powers are to be exercised and/or reviewed. This raises the question of compatibility with both the right to liberty (article 5) and the right to private and family life (article 8) of the European Convention of Human Rights.

The MDA points out that no distinction is made between ‘day-to-day’ decisions taken by a parent or carer and more significant decisions such as medical treatment or where a person should live. The MDA recommends that the legislation includes specific restrictions on the scope of the general authority²⁵.

The Law Society raises similar concerns, giving a cautious welcome to a power which offers a practical solution to the day-to-day authority to make decisions, but has ‘insufficient safeguards’²⁶. Furthermore:

‘No other jurisdiction (as far as it is known) has a General Authority as part of their substituted decision-making law. The Law Society would therefore suggest proceeding with caution so as to find a correct balance between efficacy and safeguards. The scope of a general authority in particular needs to be clearly defined on the face of the Bill. This is because it would not be realistic to expect informal carers to have regard to a code of practice.’²⁷

The Joint Committee noted such concerns and stated:

‘We strongly recommend a redrafting of the clauses concerning the general authority in order to clarify that its use is intended to be limited to day-to-day decision-making and emergency situations.’²⁸

d. Formal decision-making powers

The Explanatory Note describes the formal decision-making mechanisms as follows:

‘Most of the day to day care of adults who lack capacity will take place under the general authority with no need for any formal decision-making authority. However, in some circumstances it may be better to have a designated decision maker to act on behalf of the person who lacks capacity. The Bill sets out a number of ways in which formal decision making powers can be acquired or granted. These powers represent an extension to the current ways in which financial decisions can be taken on behalf of others, allowing decisions to be taken on welfare (including healthcare) matters as well.’²⁹

These fall into four broad categories:

- the Lasting Power of Attorney (LPA),
- Court of Protection,
- Court of Protection appointed deputies,
- Advance Decisions to Refuse Treatment.

The Draft Bill requires the Lord Chancellor to prepare ‘a code or codes of practice’ for the guidance of:

- Persons assessing whether a person has capacity in relation to any matter
- Persons acting under the general authority

25 4.5.6 & 4.5.7

26 *Submissions to the Joint Committee on the Draft Incapacity Bill from the Law Society, paragraph 3.1*

27 3.5

28 *Paragraph 119*

29 *page 10*

- Donees of the LPA
- Deputies appointed by the Court

Individuals who are acting in relation to a person who lacks capacity either in a professional capacity or for remuneration must 'have regard to any relevant code of practice'.

i. The Lasting Power of Attorney (LPA)

The Lasting Power of Attorney (LPA) will enable an individual (the donor) to appoint another person (the donee) to act on the donor's behalf if s/he should lose capacity in the future. LPAs can cover personal welfare (including healthcare) and/or property and financial affairs. Both the person who executes the LPA and the donee of the LPA must have reached the age of eighteen. The LPA must be executed in the prescribed form and in accordance with the provisions set out in the Draft Bill³⁰. Clause 4 makes clear that a person acting under the powers of the LPA is under a duty to act in the best interests of the donor.

LPAs clearly offer an important means of enabling individuals to choose who they would want to make welfare and/or financial decisions on their behalf, if they should lose the capacity to make such decisions themselves. Thus these powers have been widely welcomed in principle. However, the provisions as drafted raise a number of concerns.

For example, while Clause 10(4) makes clear that a LPA does not authorise an attorney to give or refuse consent to treatment unless the donor lacks capacity to make such treatment decisions, this does not appear to be the case for other matters. The Explanatory Notes state that a LPA can, in certain circumstances, operate as an 'ordinary' power of attorney when the donor has full mental capacity³¹ but do not explain in what circumstances this will apply.

The Royal College of Psychiatrists points out that the registration of an LPA 'appears to be an "all or nothing" event' with the loss of capacity of the donor of the LPA in one area leading to the registration of the LPA, thus giving the attorney wide powers of decision making³².

ii. A new Court of Protection

The new Court of Protection will have authority for all areas of decision-making for adults who lack capacity, including the power to make declarations in relation to individuals' capacity to make certain decisions. The Court will also be able to appoint deputies to make decisions on both welfare (including healthcare) decisions and financial matters.

Thus the two existing and separate jurisdictions in relation to decision making on behalf of people who lack capacity (the current Court of Protection in relation to financial matters and the High Court's inherent jurisdiction, in relation to other decisions) will be merged. The Explanatory Note states that by creating such a new specialised Court of Protection, with authority over all areas of decision-making for adults who lack capacity it will be possible to build and maintain expertise in matters relating to adults who lack capacity. It will have a supervisory role in relation to all decision-making mechanisms under the legislation:

30 See clauses 8 & 9 and Schedule 1, Part 1

31 Paragraph 42

32 Draft Mental Incapacity Bill – Evidence to the Joint Committee from the Royal College of Psychiatrists www.rcpsych.ac.uk/college/parliament/MIBill.htm

‘The new jurisdiction will be responsible for clarifying all issues covered by the draft Bill. It will be a superior court of record able to establish precedent and it will have the power to remove attorneys and deputies who have acted improperly. It will also be the option of last resort in cases of dispute, for example if there is a disagreement between relevant parties as to the best interests of a person lacking capacity which cannot be resolved in any other way.’³³

Part 2 of the draft Bill sets out the more detailed provision concerning the new Court of Protection, including the practices and procedures before the Court, fees and costs. A new ‘Public Guardian’ will be established. This office will have a range of responsibilities which include establishing and maintaining a register of LPAs and orders appointing deputies and supervising donees of LPAs and deputies appointed by the Court of Protection.

The Draft Bill provides a description of the type of powers that the Court of Protection can make. In relation to personal welfare matters, these include deciding where individuals may live, what contact they may have with specified persons and the giving or refusing consent to the continuation of treatment. However, there is no provision relating to specific forms of treatment despite the statement in *Making Decisions* that certain ‘serious healthcare decisions’, such as the withdrawal of artificial nutrition and hydration from a patient in a permanent vegetative state or similar condition should remain a matter for the court and not be delegated³⁴.

iii. Court of Protection appointed deputies

Where individuals lack capacity in relation to matters concerning their personal welfare and/or property and affairs, the Court of Protection may appoint a person (a ‘deputy’) to make decision on their behalf in relation to such matters. When deciding whether the appointment of a deputy is in the person’s best interest the Court must have regard to (in addition to the general issues under the ‘best interests’ provision discussed above) the following matters:

- A decision by the court is to be preferred to the appointment of a deputy to make a decision, and
- The powers conferred on a deputy should be as limited in scope and duration as possible.

As with the general authority and the LPA, there is a lack of clarity on the scope of the court appointed deputies. For example, it would seem that deputies will have the power to consent to the withdrawal of treatment.

iv. Advance Decisions to Refuse Treatment

Where a person makes a valid advance refusal of treatment this must be upheld if at a later date the person no longer has the capacity to make such decisions. Thus an advance refusal of treatment will have the same effect as if the person had retained the capacity to make such decisions. The Draft Bill provides that it will be a criminal offence for a person ‘with intent to deceive’ to conceal or destroy another person’s advance written advance refusal.

The inclusion of advance directives has been widely welcomed. However many organisations have highlighted the importance of giving legal recognition to the use of advance statements in ensuring that individuals have the opportunity of setting out their preferences on personal welfare issues

33 page 13

34 Paragraph 3.8

such as where they would like to live and how they would like to be cared for and treated, if and when there is a time that they cannot make such decisions for themselves³⁵.

3. The Aftermath of Bournewood: Interrelationship between the Draft Mental Incapacity Bill and Mental Health Legislation

The proposals in the Draft Bill raise a number of questions in relation to the adequacy of the safeguards for people who lack capacity and need treatment for their mental disorder.

Bournewood

The House of Lords' decision in 'Bournewood'³⁶ – that people who lack capacity to consent to their admission for treatment for mental disorder, but do not object, can be admitted into hospital informally i.e. without the need to detain them under the Mental Health Act 1983 (the MHA 1983) raised serious concerns about the lack of safeguards for such individuals. This was described by Lord Steyn, one of the law lords as leaving 'an indefensible gap in our mental health law'. Having referred to the safeguards that are only available to individuals who are detained under the MHA 1983, such as clear procedures for detention, a review of that detention and independent scrutiny of the decision to give treatment without consent, Lord Steyn then stressed the need to provide similar protection to people without capacity who are admitted to hospital informally:

*'Given that such patients are diagnostically indistinguishable from compulsory patients, there is no reason to withhold the specific and effective protections of the Act of 1983 from a large class of vulnerable mentally incapacitated individuals. Their moral right to be treated with dignity requires nothing less.'*³⁷

The Law Commission's recommendations

The Law Commission had specifically excluded issues relating to detention in hospital and compulsory treatment for mental disorder from its review on mental incapacity:

*'Although many people who lack mental capacity will have some form of mental disorder, few of them will require compulsory treatment in hospital for that disorder. Instead we are addressing in this report the legal problems which result from the fact that mental disorder may affect people's decision making in relation to much wider issues. The law relating to mental incapacity and decision-making must address quite different legal issues and social purposes from the law relating to detention and treatment for mental disorder.'*³⁸

However, the Law Commission considered that the Court of Protection should have powers to order individuals who lacked the capacity to make such decisions to be admitted and detained in hospital and therefore recommended:

'...the court should have the power to order the admission to hospital for assessment or treatment for mental disorder of a person without capacity, if satisfied on the evidence of two doctors that:

35 See the Mental Health Foundations response, paragraphs 3.4 – 3.6 and the Making Decision Alliance's submission 5 a. page 18.

(Also referred to as R v Bournewood Community and Mental Health NHS Trust ex p L)

36 Re L (by his next friend GE) (1998) 1CCLR 391

37 1 CCLR 390 at 408

38 Paragraph 2.2

(1) the grounds for admission specified in sections 2 or 3 respectively of the Mental Health Act 1983 exist, and

(2) it is appropriate, having regard to the “best interests” factors, that the person concerned should be admitted to hospital.’

The Law Commission considered that individuals admitted to hospital under such orders would be in exactly the same position as anyone admitted under the civil procedures of the MHA 1983, save that the right to apply to a Mental Health Review Tribunal would not arise in the first period of detention³⁹.

However, these proposals were not included in *Making Decisions* (although no explanation was given for this decision). Similarly, the Government has decided not to take forward the Law Commission’s recommendations in relation to the treatment for mental disorder for people who lack capacity to make treatment decisions. The Law Commission had recommended that the safeguards set out in the MHA 1983 in relation to the administration of medication or electroconvulsive treatment (ECT)⁴⁰ should apply to all people who lack capacity to consent to such treatment, whether or not they are detained under the Act. Under such proposals individuals incapable of consenting to medication or ECT could only be treated if an independent medical practitioner authorises such treatment.

The Draft Mental Health Bill

The Draft Mental Health Bill, published in June 2002, includes some safeguards (such as the right to apply to the Mental Health Tribunal to be discharged) for those individuals who are informally admitted to hospital for treatment for their mental disorder. The Explanatory Note to the Bill states:

‘Incapacitated patients who do not resist treatment will continue to be treated informally under common law to avoid inappropriate use of compulsion and the stigma associated with it, but the Bill will introduce a range of safeguards to guard against possible inappropriate treatment or detention.’⁴¹

However, these provisions are limited in scope as they only apply to adults without capacity who are receiving treatment for their mental disorder in hospital, whereas the Law Commission’s proposals in relation to treatment for mental disorder would have applied to all individuals who lacked capacity to consent and were receiving such treatment.

Treatment for Mental Disorder and the Draft Bill

The Draft Bill makes no provision for the treatment of mental disorder. Thus it would seem that such treatment, including electroconvulsive treatment (ECT) may be given to individuals who lack capacity to consent under the general authority – without any independent scrutiny or review⁴².

Clause 27 states that there is no authority to give, or consent to a ‘patient’ being given, treatment for mental disorder ‘if the giving of the treatment to the patient is regulated by Part 4 of the

39 Paragraph 8.29

40 Section 58 of the MHA 1983

41 Draft Mental Health Bill, Explanatory Notes, Department of Health 2002, Cm 5538-II, paragraph 187

42 See Robert Robinson, *ECT and the Human Rights Act 1998*, *Journal of Mental Health Law*, July 2003, 66 for a discussion on the practice of administering ECT under common law.

Mental Health Act'. While this makes clear that the powers to authorise treatment under the provisions of this Draft Bill will not apply to individuals detained under the MHA 1983, the Royal College of Psychiatrists questions whether this is also intended to cover all people who require treatments which are regulated under Part 4 of the Act. The College adds:

'...the draft Bill is unclear about treatment for mental disorder in incapable people not resisting treatment and not seeming to need detention. It [clause 27] could be taken to imply that psychiatrists (and social workers and general practitioners, in collaboration with family and carers) should formally detain all incapable people requiring medical drug treatment for mental disorder, regardless of the circumstances. Most incapable people would be at home or in nursing/residential homes. Such a practice would seem inordinately restrictive, inappropriate and excessively bureaucratic.'

Detention and the Use of Force under the Draft Bill

Both the general authority and the LPA permit the use of force to 'secure the doing of an act' which a person resists and the restriction of a person's 'liberty of movement', whether or not the person resists, if it is believed that the action is necessary in order to 'avert a substantial risk of significant harm' to the person without capacity.

The scope of such powers are unclear. Potentially, it would seem that these powers could be used to require a person to be admitted into hospital for treatment for mental disorder. Thus, it is not clear how these powers relate either to the House of Lords' decision in *Bournewood* or the compulsory powers under the MHA 1983. Do these powers override the *Bournewood* judgment that individuals could be informally admitted to hospital for treatment for their mental disorder only if they do not resist, by permitting the informal admission of individuals, whether or not they resist? Presumably this is not the intention of the Draft Bill and in such cases the MHA 1983 should be used, if the criteria are met. However, there is no indication in the Draft Bill or the Explanatory Notes that these provisions may overlap with the MHA and therefore no guidance is given on how professionals are to decide on which legislative procedures are to be followed, in which set of circumstances.

Conclusion

While the general consensus is that legislation to provide a clear and comprehensive framework for decision-making on behalf of people who lack capacity is urgently required, the Draft Bill requires substantial amendments if this is to be achieved. Under the current proposals the decision-making powers lack clarity. In particular the general authority is far too wide and is open to abuse. Furthermore, the relationship between the proposals, the MHA 1983 and the provisions in the Draft Mental Health Bill must be clarified. It is hoped that in addition to addressing these issues, the Government will also consider how the legislation can place a greater focus on enabling individuals to make decisions for themselves, wherever possible, for example by providing a right to advocacy.