The College

Report on the Court of Protection

Council wish to record its gratitude to the Working Party who prepared most of this Report on the work of the Court of Protection.

Remit

A Working Party on the Court of Protection was convened, at the request of Council, to undertake a detailed study of the work of the Court of Protection and to make recommendations to Council.

Introduction

At present the affairs of approximately 20,000 patients are in the hands of the Court of Protection. The location of these patients is as follows: NHS hospitals and Part Three accommodation—approximately 60 per cent; private accommodation (i.e. nursing homes, rest homes, lodgings, own homes or with relatives)—approximately 40 per cent.

About 1,750 patients are visited each year: approximately 70 per cent in nursing homes and rest homes, where a relative is not the Receiver or does not visit regularly, and 30 per cent in other private accommodation. About 5,000 new cases come under the Court's jurisdiction each year and it is anticipated that, with increased longevity, this figure may be expected to rise.

Since the Working Party's Report to Council in 1982, the Lord Chancellor's Department has reorganized both the Court itself and the Court's visiting service to patients, in accordance with the provisions of the Supreme Court Act 1981, so that, *inter alia*, the post of Deputy Master of the Court has been abolished and the Management Division of the Court has taken over the receiverships which were previously undertaken by the Official Solicitor's Department. Management Division Visitors visit each patient of the Management Division every year. A new class of 'General Visitor' has been created in addition to the existing classes of Legal and Medical Visitor. The ten General Visitors are Welfare Officers without psychiatric training, employed by the Lord Chancellor's Department, whose primary duty is to look after the welfare of the 10,000 or so employees of the Department throughout England and Wales.

Each class of Visitor is employed by the Lord Chancellor's Department but visits patients at the request of the Court of Protection and reports on the visit to the Court. The General Visitors now carry out the first, and where necessary, the follow-up visits to patients, wherever they may be living (with the exception of those in NHS hospitals, who are not routinely visited, and those in nursing homes and rest homes whose Receiver is a relative who regularly visits).

In February 1983, the full-time contracts of the two remaining Medical Visitors (Dr E. Carr and Dr A. Heaton-Ward) were terminated and they have been employed on a part-time basis since. In October 1983, three part-time Medical Visitors (Dr F. E. Kenyon, Dr R. J. Kerry and Dr P. A. Morris) were appointed. The Duties of the Medical Visitors are now confined to 'special' visits at the request of the Court to three main classes of patient: (1) those in which there is insufficient or conflicting medical evidence in the initial application for the appointment of a Receiver; (2) those in which there is an application for an ODP (Order Determining Proceedings, i.e. discharging patients from the Court's jurisdiction); and (3) those in which the patient's testamentary capacity is in doubt.

During the current year it is estimated that there will be at least fifty such cases in all. In addition, there are, this year, about seventy-five 'repeat' visits by Medical Visitors, but the number of these is expected to fall each year. There may also be a small number of patients for whom the General Visitor feels a Medical Visit would be appropriate where, for example, as suggested by the recent Report of the Royal College of Physicians, it appears that the patient's condition is being aggravated by excessive or inappropriate prescribing. The Medical Visitor has no clinical responsibility in such cases, but can make an informal approach to the patient's own doctor.

In reaching its conclusions, the College reviewed its previous recommendations to Council ((C10/82) (3)) and considered criticisms by members of the College of various aspects of the Court's work and their comments on suggestions in MIND's Special Report on the Court of Protection. The College received invaluable advice from Dr Anne Brittain, based on her long experience as a member of the Mental Welfare Commission for Scotland, and at its final meeting, had the benefit of the comments of Mrs A. B. Macfarlane, Master of the Court of Protection.

The College is opposed to any radical change in the present practices of the Court of Protection, which are based on the experience gained over many years.

In 1983, after wide national consultation, the Law Commission produced a report (Cmnd 8977) on *The Incapacitated Principal*. The main thrust of this report is that there should be incorporated in English Law the right to make an Enduring Power of Attorney (EPA). This, sometimes known as a 'Power of Attorney Against Incapacity', is already established in several jurisdictions in other English-speaking countries and elsewhere.

At present a Power of Attorney can only be made by someone in full possession of his faculties—i.e. on tests similar to those for testamentary capacity. It immediately ceases to have effect if the person becomes mentally incapable. The present proposal is thus the inverse of a current Power of Attorney—namely, it is made by someone who is well, but takes effect *only* if he or she becomes mentally incapable. (The phrase 'Enduring Power of Attorney' could thus be misleading, implying that it takes effect at once and endures if someone becomes incapable; it is in fact a *deferred* Power of Attorney against a future contingency—and thus has something in common with a will.)

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The Law Commission Report explores carefully experience elsewhere, including the difficult balance between making the procedure simple and available on the one hand and rigorous monitoring on the other. The person who is appointed Attorney will be required to register the EPA if he has reason to believe that the principal has become mentally incapable. He will be under a duty to notify all relatives and, normally also, the principal himself/herself. He will be required to keep accounts. It will be open to interested parties who feel that abuse is occuring to turn to the Court of Protection (with whom the EPA will have been registered). Although the Court of Protection is not barred from investigating or monitoring further, it will not be obliged to do so, and normally will not do so.

The College supports the institution of an EPA. It draws attention to the possible confusion deriving from that phrase, and suggests that it would be better to call it a 'Deferred Power of Attorney' or a 'Power of Attorney Against Incapacity'. It notes that the likely result should be greatly to diminish the volume of work going to the Court of Protection. It hopes that the Court will consider ways, including random enquiry, of monitoring more effectively the exercise of the Power by the appointed Attorney. It recognizes, though, that completely watertight monitoring is unlikely to be possible and indeed might negate, as the Law Commission argues, the value of the EPA by transforming a simple procedure into a complex one.

It is the Court's policy, wherever possible, to appoint a relative or close friend as Receiver and to give preference to a person holding Power of Attorney. It is recommended that there should be a statutory requirement upon the Court of Protection to appoint as Receiver the existing Attorney unless there are substantial reasons for not doing so. Where neither is suitable or willing to undertake this responsibility, the Court may appoint the Principal of the Management Division, or other appropriately qualified person, such as a solicitor, accountant or Director of Social Services, as Receiver. The Receiver is required to submit accounts each year to the Court for scrutiny. The Court is concerned to prevent possible abuses, to detect deficiences in patient care, and to suggest to the Receiver remedies which are possible within a patient's resources. It is also the policy of the Court to suggest to Receivers that they should encourage patients to assume, where they are capable, increasing responsibility for the management of their affairs, by allowing them to open savings accounts or banking accounts with an initial limit on the amount they can withdraw at one time.

The Court regards the report of Medical and General Visitors as of great assistance in achieving all these aims.

Definition of mental disorder

The College recommends that, for the purposes of Part VII of the Mental Health Act 1983 (Management of Property and Affairs of Patients), mental disorder should be construed as defined in Section 1(2) to include 'any other disorder or disability of mind', subject to the proviso in Section 1(3).

Medical certificates

The College recommends that there should be two medical certificates in support of an application for the appointment of a Receiver—one to be given by a medical practitioner, who, wherever possible, has had previous acquaintance with the patient and may be the patient's general practitioner or hospital consultant, and the other to be given by a registered medical practitioner approved under Section 12 of the Mental Health Act 1983 as having special experience in the diagnosis or treatment of mental disorder. The College considers that a receivership should not normally be made in the absence of medical evidence, but recognizes that in an emergency the Court might have to make an interim Order in the absence of such evidence.

The College recommends that there should be scrutiny of the supporting medical certificates (at present form CP3) by the Lord Chancellor's Medical Visitors, who would inform the Court of any inadequacies and, with its approval, contact the relevant medical practitioner about them when it is appropriate to do so.

Service of Notice

The College recommends that the notice of the proposal to appoint a Receiver (Form CP6) should be served on the patient in every case. Each certifying medical practitioner should be asked to indicate on Form CP3 whether he considers there is an over-riding reason why he should be present when the Notice of Proceedings is to be served. It is understood that these arrangements are being reviewed at present by the Court.

Lord Chancellor's Medical Visitors

The College recommends that it is desirable that the first visit to a patient after the appointment of a Receiver should be carried out by a Medical Visitor, other than to patients in NHS hospitals or local authority accommodation. It should be part of the Medical Visitor's duty to enquire about the patient's treatment and to discuss this with the medical practitioner concerned, if he felt it was adversely affecting the patient's capacity to manage his affairs. A General Visitor is not qualified to do this.

Review of the Court Order

The College recommends that the Court should review the necessity for continuation of the Receivership after an initial period of two years and, subsequently, after periods to be determined by the Court. This would be greatly facilitated by the use of sophisticated computer technology. This review would not supercede the patient's present right to apply for an ODP at any time. The review would be on the basis of a medical certificate provided by the patient's current medical practitioner and the certificate, as in the case of the original medical certificates, would be subject to scrutiny and, where appropriate, subsequent action by the Lord Chancellor's Medical Visitors.

Court of Protection documents

The College has examined the following documents issued by the Court of Protection and makes the comments indicated.

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Form CP1 (Originating Application): No comment (currently being amended by Court).

Form CP3 (Medical Certificate): The College suggests modification of the existing Form CP3. Form CP3 should be associated with the 'Notes to accompany the Certificate of Incapacity', prepared by the Court in consultation with the Royal College of Psychiatrists and the British Medical Association.

Form CP5 (Affidavit of Kindred and Fortune): Apart from questioning the relevance to an application for the appointment of a Receiver of Question 10 ('Does the patient hold a Driving Licence?'), the College felt it was inappropriate to comment on this form.

Form CP6 (Notice of Proceedings): No amendment recommended (currently being amended by Court).

Form CP7 (Certificate of Service): No amendment recommended (currently being amended by Court).

Leaflet PN11 (Information Pamphlet about the Work of the Court of Protection): This refers to the scale of annual administrative fees charged by the Court as set out in Rule 83 of the Court of Protection Rules 1982.

Court's Investment Policy

The College considers it would be quite inappropriate for the Court to gamble with patients' money in 'high risk' portfolios and that the Court is justified in following a conservative investment policy.

The College believes that the frequent complaint, familiar to Medical Visitors, of delay experienced by Receivers in obtaining replies and decisions from the Court in answer to written communications, arises from staff shortages. However, Medical Visitors have sometimes been able to expedite matters by arranging for a named person to be identified at the Court, with whom the Receiver can communicate by telephone when necessary.

Summary of recommendations

1. The College confirms its support for the Law Commission's proposal to create an Enduring Power of Attorney (EPA). In its deliberations it has become aware of the potentially confusing nature of this term, EPA, implying as it does that the Power takes effect and *endures*, rather than that it takes effect only at a later stage if incapacity occurs. Use of a term such as 'Power of Attorney Against Incapacity', or a 'Deferred Power of Attorney' should obviate misunderstanding and would better indicate its nature.
   The College, appreciating the balance of argument marshalled in the Law Commission Report, nevertheless feels that ways should be explored to enable rather stronger monitoring of the Power to be exercised. The present pressure on the Court of Protection should abate somewhat as the result of the availability of an EPA, and it might well be possible for the Court to give more attention to monitoring—perhaps even by random auditing of registered EPAs.
2. Mental disorder should be construed as defined in Section 1(2) of the Mental Health Act 1983 to include any other disorder or disability of mind.
3. There should be two medical certificates in support of an application for the appointment of Receiver, including one from a medical practitioner appointed under Section 12 of the Mental Health Act, 1983.
   The certificates should be scrutinized by the Lord Chancellor's Medical Visitors.
4. The notice of the proposal to appoint a Receiver should be served on the patient in every case.
5. The College recommends that it is desirable that the first visit to a patient after the appointment of a Receiver should be carried out by a Medical Visitor, other than to patients in NHS hospitals or local authority accommodation.
6. The Court should review the necessity for the continuation of the Receivership after an initial period of two years on the basis of a medical certificate provided by the patient's medical practitioner and subject to scrutiny by the Lord Chancellor's Medical Visitors.

Closure of Psychiatric Hospitals

The Public Policy Committee considered a letter from the Section for Social and Community Psychiatry urging the College to adopt a policy on the method of closing psychiatric hospitals by removing residual patients from one hospital to another. Council approved the following statement at its meeting on 20 March 1985:

> The College has been informed that in some Regions and Districts, as large mental hospitals diminish in size and approach closure, plans have been made to move and amalgamate the residual long-stay populations from several hospitals into one large hospital which would remain open for some time.
>
> The College regards such schemes as very unsatisfactory since they would both move patients to areas with which they are unfamiliar and would result in the continuation of some very large, mainly long-stay, institutions. It recommends the housing of residual long-stay patients in small units, preferably in the community, although a remaining appropriately sited portion of a hospital may be suitable. Such units should be in a community to which the patient has some current ties and not merely based on availability or a catchment area of origin many years earlier.

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Royal Society of Health

The long established Royal Society of Health has produced a 'Guide to Membership' which is available from 13 Grosvenor Place, London SW1X 7EN. Membership is open to persons employed in either the public or private sector within the health and health-related professions, nutrition and environment. (Currently the entrance fee is being waived for UK applicants.)

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