Best Interests Assessor role: an opportunity or a 'dead end' for adult social workers?

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Abstract

This opinion article explores the significance of the Best Interests Assessor role within the Deprivation of Liberty Safeguards (2007) amendment to the Mental Capacity Act (2005) in England and Wales for social workers working with adults. It considers the challenges of the role following the Supreme Court's Cheshire West (2014) judgement and the implications for BIAs of the Law Commission's 2017 plans for replacing DoLS with the 'Liberty Protection Safeguards'. The author explains why they consider the BIA role to be a valuable one for the status of adult social work as well as for people who may lack capacity to uphold their human rights, with some reservations about the risk of diluting the safeguards the current role represents for those vulnerable people.

Keywords

Best Interests Assessor – Mental Capacity Act – adult social work – Deprivation of Liberty Safeguards – human rights

Introduction

The Best Interests Assessor (BIA) role was created as part of the Deprivation of Liberty Safeguards (DoLS) amendment (2007) to the Mental Capacity Act (MCA) (2005) in England and Wales, on 1st April 2009 in response to the HL v UK (2004) judgement. This case involved a man with severe learning disabilities who was detained in hospital without recourse to legal protections because he lacked the mental capacity to exercise his rights and who the European Court of Human Rights (ECHR) judged to have been illegally deprived of his liberty. The MCA was introduced three years after HL's case came to the ECHR and was designed to offer people who are, or may be in the future, unable to make decisions for themselves legal means to ensure they are either supported to decide for themselves or have decisions made on their behalf that focus on their past and present views and best interests. The DoLS fit within the overall framework of the MCA and offers safeguards to the right to liberty where adults lack capacity to consent to their care and treatment in hospitals or care homes. The BIA role is designed to offer an independent, professional critique of the care and treatment of those subject to restrictive care plans under DoLS and in light of the requirements of Article 5 ('right to liberty and security of person') of the European Convention on Human Rights (1950).

Best Interests Assessors (BIAs) are the key decision makers within DoLS. They meet every person assessed under DoLS, consider their ability to make decisions about their lives and the necessity for the restrictions they live under. They work with the person, their family and friends, the staff in the care home or hospital they are in, those making their ongoing care decisions, psychiatrists and advocates. They report their conclusions about whether the restrictions are in the person's best interests, or not, back to local authorities who ultimately confirm whether or not the risks to the person's health are significant enough to warrant the removal of their right to liberty for a specified period of time. BIAs are, ultimately, the voice of people who may have been silenced in the process of decisions being made about their lives and whose right to disagree or to object may have been ignored.

BIAs have attracted ‘wide regard’ (Romeo, 2016, p8) since implementation and adult social work practice appears to have embraced it. Anecdotally, it appears that thousands have been trained for BIA practice since 2014 (linked to the Cheshire West judgement - explored in the legal section). The role was seen to offer a way out of the routine ‘care management’ work that is often the day-to-day practice of adult social workers in England and Wales. As blogger Last Quango in Halifax (2017) notes, ‘the role of Best Interest Assessor became a hugely desirable qualification for adult social workers who saw the opportunity to reconnect with their values as the person whose professional role was to uphold people’s human rights’.

The DoLS, however, are acknowledged to be a cumbersome and expensive process for local authorities to apply, so the Law Commission were asked, following the House of Lords report into the implementation of the MCA, to consult on and devise a replacement. During that process, there were concerns that the ‘best interests assessor role could be axed, and independent oversight of deprivation of liberty cases scrapped’ (McNicoll, 2016a). The chance of the BIA role being a ‘dead end’ for adult social workers was a real possibility. However, the Law Commission (2017a) recommended that adult social work and other health professionals in frontline work embrace the spirit of the BIA role by taking on the main assessment and decision-making work and that the BIA role be transformed into the Approved Mental Capacity Professional (AMCP) – a more specialised and powerful role focusing on those objecting to their care and treatment.

From my viewpoint as a practising BIA, BIA educator and DoLS coordinator, the type of specialist practice that the BIA role involved has had a beneficial impact on adult social work. Thousands of adult social workers have trained and acted in this role and where their work has maintained the spirit of the BIA, it has shone a spotlight on the rights and lives of people in care homes and hospitals and their families. The quality of assessments and decision-making by those trained as BIAs often improves their overall professional practice, including their wider legal literacy. However, where BIA training has not been completed there remain major challenges for those who will be asked to take on the assessment and decision-making currently undertaken by qualified BIAs as suggested by the Law Commission (2017).

The role of the Best Interests Assessor (BIA)

BIAs are commissioned by supervisory bodies (local authorities in England and health boards or local authorities in Wales) to carry out a range of the six assessments that must be completed for DoLS, as set out in the DoLS Code of Practice (Ministry of Justice, 2008). BIAs can complete the Age and Mental Capacity assessment, will complete the No Refusals and Best Interests assessments and, if they are also qualified as an Approved Mental Health Professional (AMHP), they can complete the Eligibility assessment. The supervisory body decides which assessment they are commissioning the BIA for e.g. some commission BIAs to complete DoLS capacity assessments because they consider them to be of higher quality while others commission the doctors who complete the mental health assessments to assess capacity. BIAs are expected to complete standard forms and report back their recommendations to the supervisory body to authorise.

Context for practice

Professional

Four professions (social work, nursing, occupational therapy and psychology) are able to train and practice in the BIA role according to the statutory instruments supporting the Act (Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations (2008)). It is believed that social workers are 'mostly, but not exclusively' (McNicoll, 2014) those who train and practice in the BIA role although, as they do not have to register with any regulatory body, there is no exact figure of currently qualified and practising BIAs available. A study of BIAs undertaken by Cornwall County Council (Goodall and Wilkins, 2015, p16) reported the proportion of the BIAs they were able to contact for their research and found that 87% of respondents (443 out of 507) were qualified social workers. If the DoLS were to be fully funded, rather than replaced, the Law Commission's impact assessment (2017b) noted that additional BIAs would continue to need to be trained, though they did not identify how many BIAs are currently trained and practising. As BIAs are the role that the DoLS most relies on, it is impossible that practice in this role has not affected those adult social workers who act in it.

Since the NHS and Community Care Act (1990), and continuing with the Care Act (2014), adult social workers have tended to assess and commission packages of care for adults that are then provided by increasingly private or voluntary sector agencies. This means that the core work of direct contact with service users is often limited solely to assessment. As Anon (2016) notes, the main role of adult social workers is solely focused on acting as 'stringent gatekeepers to dwindling resources' (p403) and as 'simply brokers for competing alternative providers' (p404). This administrative role has dominated so that 'caseloads could be increased as each social worker could offer a limited engagement with more service users' (p404). This 'care management' role has become increasingly distant for adult social workers from direct working with disadvantaged individuals and communities or advocating for their rights against the interests of local authorities. In my experience as an adult social worker, it was not unusual for managers to remark that you didn't need to be a qualified social worker to carry out care management tasks which left social workers demoralised and deskilled. It is little wonder then that a role fundamentally based in human rights and advocacy, such as the BIA, has offered adult social workers a renewed sense of satisfaction, despite the high workloads involved (Fowler, 2015), especially as within adult social work there are few specialist practitioner roles available for those wanting career progression.

The professional standards for adult social work support this development e.g. the Knowledge and Skills Statement for Social Workers in Adult Services (Department of Health, 2015a) puts work using the wider MCA firmly at the heart of the early careers of social workers practising with adults in England and Wales. From this the BIA role acts as a specialist practice development and CPD opportunity for experienced social workers with adults once they have been practising as qualified for two years. As Beddow et al (2015) note social workers practising at 'experienced' level on the Professional Capabilities Framework (BASW, 2017) can develop their skills in applying the MCA by training for and acting in the BIA role (p14).

There is also academic progression as BIAs in England must complete training that attracts academic credits, often at Masters level, at one of the currently 25 training providers

approved by the Department of Health (2016). BIA training in Wales is organised by supervisory bodies and, at present, does not require a qualification accredited by a university (Care Council for Wales, 2015, p7) though some Welsh local authorities do support their BIAs to achieve academic qualifications.

Case law: Cheshire West

The decision in the P v Cheshire West and Chester Council and P and Q *v* Surrey County Council (2014) case at the Supreme Court (known as "Cheshire West") lowered the understanding of where the threshold for care and treatment of those who might lack capacity to consent that is considered to amount to a deprivation of liberty. The judgement considered the cases of three adults whose care was managed outside of DoLS and set out the definition (or "acid test") of who could be considered to be deprived of their liberty as a person who is 'under continuous supervision and control and is not free to leave' (p20). The Supreme Court rejected previous views that if the purpose of the care planned was benign then the person could not be deprived of their liberty - 'a gilded cage is still a cage' (p19) – as well as comparison with another similarly disabled person rather than a person without disabilities - the 'relative normality' approach (p19). The Court also held that the person's objection, or lack of, were irrelevant to whether the person was deprived of their liberty or not (p20). This meant that many of those who lacked capacity to consent to their care or treatment in a care home or hospital in England and Wales e.g. because of dementia were considered to be deprived of their liberty, where previously only those who had been objecting or were trying to leave were considered to have had their right to liberty breached.

Operational

Local authorities in England and Wales (and health boards in Wales) are responsible for appointing sufficient BIAs in their guise as 'supervisory bodies' and there are a range of different organisational models that BIAs work within as a result. Prior to the Cheshire West judgement, there were usually individual professionals, often also practising BIAs, running DoLS services for supervisory bodies, with several qualified BIAs working on a rota.

After Cheshire West, the number of applications for DoLS assessments coming from care homes and hospitals increased hugely. The Health and Social Care Information Centre reported a tenfold increase in applications in England in 2014-15 (2015, p5) and NHS Digital (2016) reported applications doubled in 2015-16 in England. Applications in Wales in 2014-15 increased sixteenfold (Care and Social Services Inspectorate Wales / Healthcare Inspectorate Wales, 2016, p2) and by over 15% in 2015-16 (Care and Social Services Inspectorate Wales / Healthcare Inspectorate Wales, 2017, p3).

Supervisory bodies recognised quickly that they did not have enough BIAs to meet this demand. They responded to the Cheshire West judgement by increasing the number of staff being trained for the role, though concern was expressed about what impact the demand for quantity of BIAs has on the quality of the training they receive (Brown, 2014) and using a range of ways to employ BIAs to meet demand (McNicoll, 2014). For example, supervisory bodies have increased the number of assessors they can call on and organised their responses to the demand for DoLS assessments in their area in many ways. BIAs can be employed in specialist DoLS teams, act as BIAs occasionally on a rota that takes them out of their usual

work role, be employed through an agency to carry out DoLS assessments for supervisory bodies or work as independent BIAs for a number of supervisory bodies.

Since the abolition of primary care trusts (PCTs) in England on 31st March 2013, local authorities in England have been solely responsible for the operation of the Deprivation of Liberty Safeguards in England. NHS bodies have been less likely to support their staff to train as BIAs as they see the role as a local authority responsibility now they no longer have a role as supervisory body for the care provided in hospitals.

Professional: post-Cheshire West

Prior to the Cheshire West judgement, strict statutory timescales were adhered to for the completion of assessments. Since Cheshire West, other pressures have set the timescales for BIA assessments including the nature of supervisory body rotas, commissioning arrangements for independent assessments, the workload pressures on supervisory bodies and the ongoing budget restraints on local authority finances. The Goodall and Wilkins (2015) time study aimed to find out whether BIAs were experiencing time pressures on their practice following Cheshire West which could impact on the quality of the assessment completed. They found that the average (mean) length of time taken by BIAs for each assessment was 12 hours though they were keen to point out that with the broad range of results they found this figure could not be relied upon to give an accurate guideline for usual practice (p46-47). They found that the main variables that could determine the length of a BIA assessment were

- Whether the work is an 'initial' or 're-assessment' for a further period of authorisation
- The type(s) of assessment required (Best Interest, Age, No Refusals, Eligibility and Capacity)
- The predicted level of difficulty or 'complexity' of the work (Goodall and Wilkins, 2015, p43)

The study's BIA respondents experience of time and how long it takes to undertake a DoLS assessment is seen, not in terms of 'time and task', but in terms of the 'complexity' of the work and the bureaucracy of the scheme' (p48). This suggests that variability in terms of the time it takes is a necessity born of both the nature of the people that DoLS applies to and the nature of the current legal framework for DoLS work. In my experience, it is unpredictable how long BIA assessments will take and quality of assessment often comes from the time taken to observe the person's behaviour and environment, look through records, talk to professionals, carers and families and explore the decision-making process that lead the person to their current residence. The revised proposals made by the Law Commission (2017) suggest this role will be picked up by frontline social workers and health professionals who have not received specialist training, will have the pressures of their usual work to complete and are effectively being asked to scrutinise their own decision-making.

BIAs take on an independent scrutiny role for health and social care where those who lack capacity to consent have had decisions made to restrict their freedom to choose where they live and the level of care they receive. It is an additional safeguard to ensure that overly restrictive or protective decisions are not made contrary to the person's wishes unless absolutely necessary. This does not always make BIAs popular with commissioners or providers of care, or families where the person is self-funding, as they may disagree with decisions that have been made or question judgements that are well-established. Their

independence from this care decision-making is a significant element of the value of the BIA role. Removing this layer of safeguard because it is not financially viable to continue risks placing poorly made, unnecessarily restrictive judgements back in the dark away from questions or scrutiny.

Legal framework: reform of DoLS

It is not just in the courts that the role of the BIA has been changing. One week before the Cheshire West judgement was published in March 2014, The House of Lords Select Committee on the Mental Capacity Act (2005) presented their report on the implementation of the MCA in England and Wales (House of Lords, 2014). The report praised the MCA, calling it ‘a visionary piece of legislation for its time’ (p6) though it noted that its implementation had ‘suffered from a lack of awareness and a lack of understanding’ (p6). There have been concerns raised, however, that the MCA’s reliance on substitute rather than supported decision-making does not meet the requirements of Article 12 of the United Nations Convention on the Rights of People with Disabilities (UNCRPD) (2006). The DoLS, which the Select Committee had also considered, was not viewed as well. It was called ‘poorly drafted, overly complex and bear no relationship to the language and ethos of the Mental Capacity Act’ (p7). The only recommendation made was to scrap DoLS and start again. The Law Commission were asked to take on the job of drafting and consulting on a replacement which was eventually published in their final report and draft legislation in March 2017. They have proposed a scheme called the ‘Liberty Protection Safeguards’ (LPS) (2017a). This new legal framework will be an amendment to the MCA, including a revised MCA Code of Practice, and will apply to those 16 and over (rather than 18 and over) where their care and treatment amounts to a deprivation of liberty. It focuses on the planned arrangements for care and treatment, rather than where the person is currently residing, so it can be applied in hospitals, care homes, supported living, Shared Lives, the person’s home, day centres and even transport between these. This means that new applications would no longer be necessary when the person moves or goes into hospital and applications would not be needed to the Court of Protection (sometimes called ‘domestic’, ‘judicial’ or ‘community’ DoLS) if a person lacks mental capacity to consent to their care or treatment outside hospital and care home.

This new approach would put the responsibility for assessment and decision-making around deprivation of liberty in the hands of the bodies responsible for initially commissioning the person’s care and treatment e.g. local authorities and NHS bodies, rather than relying on care homes or hospitals to know when their residents are being deprived of their liberty. Social workers and nurses would be completing ‘capacity’ and ‘necessary and proportionate’ assessments where deprivation of liberty has been identified in their plans. All decisions to plan care and treatment that amounts to a deprivation of liberty would be independently reviewed within the local authority or NHS body deciding on the care plan to check that the criteria for LPS had been met through scrutiny of the documents completed (p96-7) and may decide to refer to an AMCP, if necessary.

The AMCP role is designed as a replacement for the BIA role but with a narrower focus on cases of higher risk as BIAs are seen as a valuable, specialist resource but too expensive to be available to all those whose rights may be infringed by care and treatment decisions (Department of Health, 2015b). The Law Commission proposed the AMCP role to consider

decisions on deprivation of liberty where the person involved objects to their care and treatment, where there is a risk of harm to others and other discretionary situations (Law Commission, 2017a, p97-103), and to decide whether these should be approved or not. The role is to be designed to have equal status with the role of the Approved Mental Health Professional (AMHP) – a well-established statutory role under the Mental Health Act (1983, amended 2007). Those acting in the AMCP role would be employed in specialist teams line managed separately from those making decisions about how care and treatment is provided to remain independent and to allow questioning and scrutiny of relevant deprivation of liberty care and treatment decisions (p107-8). It is clear that there will be legal, professional and operational implications of these changes, not least where those already trained as BIAs will go within this new framework.

Views of the BIA role

Alistair Burt, Minister of State for Community and Social Care, highlighted the value of DoLS assessments in the House of Commons on 17th June 2015:

> 'Although some may baulk at the idea of 100,000 DoLS applications a year, we should remember that every one of those applications represents a person having their care independently scrutinised. DoLS can help shine a light on care that is unnecessarily restrictive and does not put the person's views first and foremost' (quoted in Richards and Mughal, 2015, piii).

This is the main value of the BIA role – BIA's sole purpose is to illuminate decision-making and ensure possible alternatives have not been sidelined. The Law Commission pointed out that 'the role and expertise of the best interest assessor is a highly-regarded aspect of the DoLS' (2015, p75) and noted that the 'role of the Best Interests Assessor as a particularly important one' (2015, p72) for the rights of those subject to DoLS assessments. In the time since the implementation of DoLS, BIAs had 'turn[ed] their attention to a broad range of issues including the suitability and quality of the particular placement and not merely the need to deprive the individual of liberty for medical treatment', 'were often the "linchpin" of the system' and 'has developed into a knowledgeable and well-respected quasi profession' (2015, p75).

From my experience of educating, supporting and scrutinising the practice of BIAs, I have seen that BIA education and practice has improved assessment, decision-making and recording practice by BIAs in wider social work practice, especially when assessing capacity and making best interests decisions – a view that has been supported by the comments of both students and their senior managers. Both managers and practitioners have told me of greater confidence and capability in applying the law to practice and in evidencing decision-making which suggests that the knowledge and skills of adult social workers has potential to be improved and expanded in this way.

The benefit of BIA practice should not just be to the quality and status of the professionals themselves. It is essential that the role improves the outcomes of those who experience BIA assessments. The Richards (2016) study set out to verify whether and what positive outcomes came from BIA assessments following criticism in the Law Commission's interim report

(2016) that DoLS assessments 'failed to deliver improved outcomes for people who lack capacity' (p7). The study consisted of an online survey of 92 BIAs 'who provided a total of 468 positive outcomes' (p1). The main categories of positive outcomes included:

- Finding the person had capacity – Richards called it 'the most regular and startling outcome of the BIA assessment (62 out of 468)' (p1) which suggested that care providers and managers were not confident or skilled in assessing the capacity to consent to care of those they care for without the contribution of independent, skilled practitioners
- 'Person returned to live at home/community' (p2) – rather than remaining in the care home or hospital the person could return to more individual and personal surroundings as a result of the contribution of the BIA
- 'Improved social activities/access to the community' (p2) – the 'second most reported outcome (56 out of 468)' which suggested that unscrutinised, overly restrictive care was preventing people unnecessarily from leaving care settings or engaging in activities within the home
- Other positive outcomes included helping families and other professionals understand and use the Mental Capacity Act better, reviewing inappropriate care plans and placements, encouraging less restrictive care, reducing the use of unnecessary sedating medication, increasing contact with family and identifying and addressing Safeguarding Adults concerns (p3-4)

There is a high chance that those responding to this survey were a self-selected group of those who already held a positive view of DoLS and the role of the BIA. However, the number of positive findings and consistent themes suggest that, despite the flaws of the DoLS system, positive outcomes as a result of BIA actions are possible and can have a profound effect on the lives of those being assessed.

It is important to note that not all views of the BIA role are positive. The Law Commission in the final report on their consultation (2017a) noted some disagreement with comparing the BIA role to the AMHP as 'the latter role has over 30 years' history and culture behind it, whereas the best interests assessor role had not had time to "bed-down". Some argued that currently BIAs sometimes lack the professional confidence to challenge other decision-makers, especially doctors' (p105). Hubbard (2012) noted that BIAs had been considered as a less regarded role than AMHP and there was a risk during the consultation process that the role could have been abandoned altogether (McNicoll, 2016a). It is clear that Law Commission consider the expertise of the BIA significant enough to develop into a more responsible and independent role as evidenced by their plans for the AMCP.

The future for the BIA role and the implications for adult social workers in England and Wales

This is a good time to consider the future of the BIA role as the Law Commission's plans for the LPS gave a clear message that the expertise developed by BIAs in decision-making on deprivation of liberty should not be lost. There are three key questions for the professionals trained as BIAs:

1. What value will those already qualified as BIAs have in the future?

The skills and knowledge of BIAs will be needed by those working in 'responsible bodies' e.g. social workers and health professionals acting on behalf of local authorities and NHS services to carry out their capacity assessments and make their 'necessary and proportionate' decisions. They will be needed by independent reviewers and those authorising LPS assessments within these responsible bodies to ensure that the quality of evidencing decision-making is maintained. They will be needed by the AMCPs who will scrutinise the assessments and decisions made by other professionals on contested deprivation of liberty decisions and who will have the power to authorise these deprivations of liberty or not.

The skills and knowledge of those already trained and practising as BIAs will be invaluable to those who are newly taking on work related to deprivation of liberty. Existing BIAs bring a heightened legal literacy and confidence in working in a human rights driven manner that will remain a valuable resource for those services already working with human rights. Last Quango in Halifax (2017) believes that the AMCP role 'is a lifeline being thrown to the adult social work profession and it should be grabbed with both hands. It is a role most naturally suited to social workers with adults because since 2014 we have rapidly embraced and consolidated our expertise, knowledge of and passion for human rights and the Mental Capacity Act (2005).' The Law Commission have recognised that BIAs will need conversion training to become AMCPs and that existing BIA training providers will be in a strong position to convert to becoming AMCP training providers.

On an individual level, it is hard to imagine that those social workers and health professionals that will be asked to take on LPS assessments are going to take this work on with confidence if they have not trained as BIAs. On the BIA qualifying module I teach, experienced and qualified professionals take time to understand the complex legal and procedural knowledge required for BIA practice. Without this time for comprehensive learning, what confidence can there be in the deprivation of liberty decisions that will be made?

2. What impact will the Liberty Protection Safeguards have on adult social work?

The Law Commission's plans (2017a) have set out a range of ways that the BIA role can inform and increase the status of adult social work practice in the future. Lynn Romeo, Chief Social Worker for Adults stated that the proposal for the future role of BIAs 'reflects my belief that the future for excellent social work practice lies in recognised, post qualification advanced specialist knowledge and skills' (Romeo, 2016, p8). A close reading of the proposed LPS framework shows that, though it is likely that fewer social workers will undertake the training for a specialist role like BIA in the future as there is likely to be a reduced need for AMCPs, the knowledge and skills required for adult social work practice with deprivation of liberty will build on the knowledge base that BIAs have. There is also the potential for social workers to take on the independent reviewer role. These specialist roles offer routes for professional development within usual adult social work practice.

3. What challenges will there be for professionals taking on new roles under the Liberty Protection Safeguards?

LPS assessments

The Law Commission's plans assume that the knowledge of the legal framework for deprivation of liberty assessments and decisions will be a fundamental part of the practice of those making decisions that may infringe on people's Article 5 rights. Adult social workers and other health professionals will need to develop the skills and knowledge required for day-to-day liberty rights work and those who are already BIAs will have a distinct advantage. My experience of working with social workers asked to take on Court of Protection deprivation of liberty assessments suggests that those not qualified as BIAs struggle to understand the concepts and requirements involved. Without significant extra time for training and support there is a high chance of poor decision-making affecting the rights of those detained. It is worrying that the system the Law Commission propose puts the decisions about restrictive care into the hands of those making care decisions without the added scrutiny offered by a BIA assessment. Mark Neary (2017), whose son was deprived of his liberty for a year as a result of insufficiently independent DoLS decision-making (Hillingdon v Neary, 2011), identified that 'the person making the case for the LPS will already be involved in the person's care planning' and removes the necessity of independent scrutiny e.g. by an AMCP unless the person is seen to be objecting to their care. The Court of Protection appeals route is also likely to remain under the Law Commission's plans so those subject to this type of detention will continue to miss out on more local and available routes of appeal e.g. via Mental Health Act Tribunal.

Adult social workers will be asked to integrate LPS work into their already pressured caseloads. What chance will there be of sufficient time to learn the new knowledge and skills required for these decisions, let alone find time for often complex assessment and decision making? The Law Commission's impact assessment (2017b) suggests that adult social workers and other frontline professionals will be informed of the requirements as part of their usual training programmes, even though most frontline staff in my experience have a very limited understanding of DoLS at present. Health professionals, such as nurses working for NHS Continuing Health Care (CHC) teams or hospitals as responsible bodies, will also need to make LPS decisions and with a lower number of trained BIAs in these settings there is reason for greater concern about the availability and quality of the professionals making these decisions.

Independent reviewers

This role is proposed to oversee all LPS assessments on behalf of the responsible body and consider whether the requirements have been met for authorisation. The scrutiny would be based on the paperwork only and would have the power to refer to an AMCP if required. This appears a similar role to the DoLS Coordinator post that I held for one year. I saw hundreds of BIA assessments during that year and gained a clear sense of the qualities that made a defensible or non-defensible assessment. It was invaluable to my understanding of how to approach teaching BIAs to record assessments. It was also a thankless task reading numerous assessments of significantly varying quality and I remain unconvinced that a well written assessment is always a true reflection of a competent assessment process, despite ADASS considering desk-top assessments an appropriate interim measure while DoLS assessments remain incomplete (McNicoll, 2016c).

It is not yet clear who will carry out the role of an independent reviewer. It would make sense for qualified and experienced BIAs to be considered to have the relevant knowledge and

skills for the role but the Law Commission (2017) have given no guidance on who responsible bodies should appoint. They also do not mention a training cost to ensure that these reviewers understand the quality of assessments and decisions they should expect to see. Considering the number of DoLS applications that have been made since the Cheshire West judgement it is likely that these reviewers will continue to have a significant caseload to review.

Approved Mental Capacity Professionals (AMCPs)

The opportunity to develop the BIA role into one of equal status with AMHPs is a valuable one. The need for those acting as AMCPs to be further removed from care decision making within responsible bodies and to have the power to refuse to authorise allows these practitioners a significant level of professional autonomy. Since many local authorities have embedded the BIA role into career progression and CPD pathways it is likely that the loss of the BIA as a specialist development role would have hit the retention levels of adult social workers of local authorities. However, the limited nature of the proposed AMCP role to scrutinising decisions only where the person is objecting or where the risk to be managed is posed to others is likely to limit the scope for independent scrutiny and the ability of those trained and acting as independent BIAs to continue. The number of 'routine' DoLS assessments that I have seen or been involved in that with brief scrutiny tuned out to be anything but routine are concern me when I read about the Law Commission's plans. Would the unqualified reviewer responsible for the man with learning disabilities and no verbal communication, who I assessed, that had not left his care home for six months according to his care records, despite the very active care plan that had been written, notice this if I had not? Would the woman with a chronic degenerative condition, who had not left her bed since being admitted to a care home who had no idea how to manage her condition, ever have left her bed if I had not insisted that equipment and training must be found and used? The benefit of a fresh pair of critical eyes in Eleanor Roosevelt's (1958) 'small places close to home' are what BIAs offer, whether superficially the person's care looks complex or not, and this is what risks being lost if the BIA role is limited to only a few circumstances.

Conclusion

At the time of writing, no response has been received from the UK Government about how the Law Commission's final report and draft bill have been received. Many questions remain, not least how long will it take for the amendments to the MCA, new regulations and revised MCA Code of Practice to go through Parliament and for these changes to be enacted, especially since the destabilising result of the 2017 UK General Election. What impact these changes will have on those social workers trained and acting as BIAs England and Wales is a matter of speculation, though it is clear that the BIA role has offered a valuable route for specialism and professional identity within adult social work.

However, what is most important is what impact these changes in the Liberty Protection Safeguards could have on the human rights of those it affects. Crucially, they will lose universal independent scrutiny of their restrictive care and treatment, not just of the written assessment but of the whole picture of the person including what they have to say about their care. It can be argued that this is not universal at present as many local authorities have not been able to send BIAs to all those on their waiting list. The crucial point is that the universal right of the person to be seen by an independent, knowledgeable professional remains –

without that right, how will the voiceless regain their ability to question and challenge decisions?

What you can be certain of is that the experience gained by BIAs of focussing on human rights, scrutinising care decision-making, highlighting the views of the individual about their care and treatment, negotiating with often divergent views and recording a professional analysis of a complex decision is not wasted effort. Adult social work has changed for the better as a result of embracing the BIA role and working to promote the views and wishes of often voiceless people that their day-to-day work often does not allow for. The experiences of many who have been subject to DoLS assessments and had their legal rights and views supported and considered must not be ignored in the quest for a simpler system.

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