Foreword

Welcome to this updated workbook on the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS) designed and developed by the National Centre for Post-Qualifying Social Work at Bournemouth University in partnership with Learn to Care, the professional association of workforce development managers in local authorities.

This is an accessible and informative workbook, packed full of case studies, activities and advice about the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS). We hope it will support practitioners to improve their professional practice and develop their knowledge and skills within key legislative and ethical frameworks.

We would like to extend our thanks to Mike Lyne from the National Centre for Post-Qualifying Social Work for putting together the content of this workbook.

All joint publications by Bournemouth University and Learn to Care are available for purchase on the National Centre for Post-Qualifying Social Work website: http://www.ncpqsw.com/publications/

We trust that this workbook will be a clear and useful resource for those who wish to learn more about the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS).

Professor Keith Brown
Director of the National Centre for Post-Qualifying Social Work

Anne Connor
Chair of Learn to Care

May 2014

Introduction

This workbook is designed to enhance your knowledge of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS) process.

A key part of the 'DoLS puzzle' is the *Mental Capacity Act 2005 Deprivation of Liberty Safeguards Code of Practice to supplement the main MCA 2005 Code of Practice* (the DoLS Code of Practice). You cannot undertake your duties as a professional without access to a copy of the Code which is available either as a hard copy or a download from the Office of the Public Guardian. The DoLS Code needs to be read and considered alongside the main MCA Code of Practice as, like the DoLS process, it does not stand alone.

Throughout the workbook you will find scenarios and quiz questions for you to answer either via your own knowledge or via quick research. A good source of information about DoLS is the website of the Ministry of Justice. The workbook has been revised to take account of the most recent judgements in the courts.

Many of the scenarios are reproduced from the Code of Practice which is Crown Copyright. There are also a number of reflective questions which encourage you to consider your own working practice in the context of capacity.

Questions in the Quiz have been adapted from "Who wants to be a BIA?" used in the standalone BIA training provided by Bournemouth University and written by Esther Vernon.

Wherever possible the workbook avoids *legalese* but because of the nature of the topic, some legal language is inevitable. This will be explained as far as possible. Try not to let this put you off and have fun!

Michael Lyne
May 2014

Acronyms and Glossary

BIA	Best Interest Assessor
CoP	Code of Practice
COP	Court of Protection
DoLS	Deprivation of Liberty Safeguards
IMCA	Independent Mental Capacity Advocate
MA	Managing Authority (the care provider)
MCA	Mental Capacity Act 2005
MHA	Mental Health Act 1983
SB	Supervisory Body (a Local Authority)
The Relevant Person	The person who is receiving the care and is at risk of being deprived of their liberty.

Legal Context

- European Convention on Human Rights

- Article 5 (1)
  'Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save… in accordance with the procedure prescribed by law'

- Article 5 (4)
- 'Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily be a court and his release ordered if the detention is not lawful'

"Deprivation of liberty" is only half a sentence. In order to put it into its proper context one should always add on the second part of the phrase which is either "deprivation of liberty in breach of, OR in accordance with Article 5, European Convention on Human Rights" (ECHR), even if one only does this in one's head.

Article 5(1), as quoted above gives a basic right to liberty and security and says that liberty can only be taken away as long as it is done using a procedure set out in a nation's laws. The person being deprived of his or her liberty also has to fit into a group, also outlined in Article 5. These groups include criminals and, for our purposes, "persons of unsound mind".

The usual "procedure prescribed by law" for persons of unsound mind in England and Wales is the Mental Health Act 1983 (MHA)

Article 5(4), ECHR, gives a right to a legal review of any deprivation of liberty. Criminals, under certain circumstances can appeal against conviction and sentence. Person's detained under the MHA can appeal to either a panel of hospital managers or the First Tier Tribunal (Health, Education and Social Care Chamber), also known as the Mental Health Tribunal.

The importance of Article 5 will be seen as we progress through this workbook.

Acting Lawfully in Connection with Care and Treatment

- Mental Health Act 1983
- Mental Capacity Act 2005 – section 5 provides protection from liability provided MCA requirements are met
- Includes personal care, healthcare and treatment
- Section 6 allows physical restraint if – last resort, proportionate, meets MCA criteria
- Specifically excludes deprivation of liberty

In health and social care terms there are a number of ways in which care and treatment can be provided.

Firstly, the MHA authorises treatment for mental disorder. People detained under that Act can be forcibly treated with medication against their will for up to three months before safeguards come into play. These safeguards include obtaining authorisation for the treatment by a second independent doctor.

Section 5 of the Mental Capacity Act 2005 does not authorise treatment. But it does provide practitioners with protection from liability in connection with care and treatment where that care and treatment would otherwise be an assault if the person had capacity to consent to or refuse the care.

In order to use section 5 safely, one would first have to establish that the person who needs the care or treatment lacks capacity. Then the practitioner would need to follow the best interests checklist as set out in the MCA Code of Practice. Assuming that these steps have been taken and the practitioner is happy that the care or treatment is in the person's best interests, the practitioner could then proceed with the act. Detailed and extensive recording is essential for the correct and safe use of this section.

Questions

Does your authority have internal paperwork for this purpose?

Where will you find it?

Section 6, MCA allows restraint assuming that restraint is proportionate, a last resort and in the person's best interests. Restraint can only be in order to prevent harm to the person themselves. Restraint in this connection would include such actions as having a colleague hold the person's arms to stop them hitting themselves, for instance. However, restraint cannot be so great that it adds up to depriving the person of their liberty. A useful resource here is [1]

Questions

Does your authority have internal paperwork for this purpose?

Where will you find it?

[1] Department of Health. 2014. Positive and Proactive Care; reducing the need for restrictive interventions. London: TSO

Finally, the courts can also authorise treatment. The courts would be particularly crucial in authorising treatment for incapacitated persons where that treatment might be life saving for instance.

HL v The United Kingdom [2005] 40 EHRR 32:

- HL was incapable of making decisions about his residence and treatment
- He was admitted to hospital for in-patient investigation and treatment
- Contact between him and his long-term carers was initially prohibited while he remained in hospital, and then subsequently restricted by the hospital to one visit a week
- He was sedated while in hospital which "ensured that he remained tractable", although he was not so sedated while in the community
- He was kept under continuous observation by nursing staff
- Those responsible for his care indicated that, if he tried to leave the hospital at all, then they would arrange for him to be assessed with a view to detaining him under the Mental Health Act 1983.

This case, known as the 'Bournewood' case, is the foundation for the Deprivation of Liberty Safeguards (DoLS). HL was a middle aged man who suffered from autistic spectrum disorder and who also had an inability to communicate. He had been discharged from Bournewood Hospital following a long admission. He was moved into a home with the 'E' family and for the most part did extremely well with them. He was also attending a day services centre as part of his care plan.

One day whilst at the day services centre he became agitated and upset and started to self harm by hitting himself in the face. The staff at the day centre were unable to identify why he was upset and asked his GP to see him. The GP assessed him, gave him some sedation to calm him down and decided that he needed to be assessed under the MHA. A psychiatrist and Approved Social Worker as required by that Act at the time assessed him and decided that he needed to come into hospital. The Act requires staff to use the "least restrictive alternative" and so they asked HL to go into hospital as a voluntary patient. He did not refuse and did not appear to be objecting so was escorted onto the hospital ward and admitted as an 'informal' patient.

One of the major differences between being admitted as an informal patient and being detained under the MHA is that informal patients have the absolute right to get up and leave at any point, discharging themselves if they wish. Patients detained under the MHA cannot leave without staff permission or discharge themselves. However, they do have the right of appeal as mentioned above. Both the hospital managers and the Tribunal have the power of discharge.

In order to exercise either right though, one has to know that one has them. HL did not have the capacity to understand that he could get up and leave at any time

and even if he had had, the clinical team stated that any attempts by him to leave would have meant detention under the MHA and indeed, after three months, HL was actually detained under the Act. At this point, his rights under Article 5 were effectively restored.

The hospital initially refused the 'E' family access to see HL. When they were eventually allowed to visit, they were limited to one visit a week. The 'E' family argued that prior to his formal detention, HL was being deprived of his liberty against his rights under Article 5 and decided to take legal action.

ECHR Ruling

"It is not disputed that in order to determine whether there has been a deprivation of liberty, the starting-point must be the specific situation of the individual concerned and account must be taken of a whole range of factors arising in a particular case such as the type, duration, effects and manner of implementation of the measure in question. The distinction between a deprivation of, and restriction upon, liberty is merely one of degree or intensity and not one of nature or substance …" (Guzzardi v Italy (1980) 3 EHRR 333)

*"The Court considers the key factor in the present case to be that the health care professionals treating and managing the applicant exercised **complete and effective control** over his care and movements from the moment he presented acute behavioural problems …to the date he was compulsorily detained."*

Legal proceedings initially took place in the domestic courts before eventually ending up in the European Court of Human Rights. The question for the Court was had HL been deprived of his liberty contra to Article 5 for the three months prior to his detention under the MHA.

The Court made a number of comments in relation to the case which have subsequently become the foundation of deciding what is more likely to be and what is less likely to be a deprivation of liberty. A number of key sentences have been taken from the whole. The sentences to particularly reflect on include, *"the type, duration, effects and manner of implementation", "the distinction between deprivation of and restriction on liberty is one of degree or intensity, not nature or substance"* and *"the professionals exercised complete and effective control over his care and movements".*

ECHR Ruling II

"The correspondence … reflects both the carer's wish to have the applicant immediately released to their care and, equally, the clear intention of Dr M and the other relevant health care professionals to exercise strict control over his assessment, treatment, contacts, and, notably, movement and residence …"

"The applicant's contact with his carers was directed and controlled by the hospital … the concrete situation was the applicant was under continuous supervision and control and was not free to leave"

"In this latter respect the court finds striking the lack of any fixed procedural rules by which the admission and detention of compliant Incapacitated persons is conducted …"

Further key sentences include the professionals exercised *"strict control over his assessment, treatment, contacts…movement and residence"* and *"the applicant was under continuous supervision and was not free to leave".*

The last sentence above has become key to our current understanding of what constitutes a deprivation of liberty following the recent Supreme Court decision *P (by his litigation friend the Official Solicitor) v Cheshire West and Chester Council and another: P & Q (by their litigation friend the Official Solicitor) v Surrey County Council [2014] UKSC 19* (also known as the *Cheshire West* case).

Baroness Hale, giving the lead judgement in *Cheshire West* developed what has become known as the "acid test" (see below). However, section 64 MCA 2005 states that the definition of deprivation of liberty in England and Wales is the same as that used in Europe. Some of the *Cheshire West* justices believed that Baroness Hale had gone too far in trying to give a single definition of deprivation of liberty as this is something that Europe has not tried to do.

Identifying Deprivation of Liberty using the factors identified by the European Court of Human Rights:

- Restraint used, including sedation, to admit a person who is resisting
- Professionals exercising complete and effective control over care and movement for a significant period
- Professionals exercising control over assessments, treatment, contacts and residence
- The person would be prevented from leaving if they made a meaningful attempt to do so
- A request by carers for the person to be discharged to their care being refused
- The person is unable to maintain social contacts because of restrictions placed on access to other people
- The person loses autonomy because they are under continuous supervision and control.

When added to a further element, the inability to maintain social contacts including being able to make visits into the community or having visitors into the hospital or care home, the overall total leading to a loss of autonomy might very well give rise to the suspicion of a deprivation of liberty.

Reflective Question

Think about the people you are working with or have worked with in the past. Do you think that any of them could possibly have lost their autonomy?

As well as the indications mentioned above, it is important to understand the case law as it is this which guides us in trying to decide the person's status. In *Cheshire West the* judges stated that as well as the 'acid test', the person concerned actually has to be confined somewhere for a not insignificant period of time; did not or could not consent to that confinement; and that the confinement was in some respects the responsibility of the State. These three considerations are known as the 'Storck elements' as they arise from *Storck v Germany (61603/00) [2005] 1 MHLR 211.*

Baroness Hale suggests that because most of the case law includes the following phrases in some form that this should be known as the **'acid test'** – *"is the person subject to continuous supervision and control"* and *"is the person free to leave"?*

Note that the person has to be both subject to continuous supervision and control <u>and</u> has to be not free to leave before they could be considered to be deprived of their liberty.

One problem which has been identified is that Baroness Hale and her colleagues did not define what being subject to continuous supervision and control actually means? Does it mean that the person is being observed at all times by a member of staff? Or is it possible to be under continuous supervision but in a less intrusive way?

The judge in another recent case which predates *Cheshire West* outlined what the court would look at, at that time, when defining deprivation of liberty. This is certainly one way of trying to decide whether someone is under continuous supervision and control, especially the second paragraph.

"When determining whether there is a 'deprivation of liberty' within the meaning of Article 5, three conditions must be satisfied, (a) an <u>objective</u> element of a person's confinement in a certain limited space for a not negligible time; (b) a <u>subjective</u> element, namely that the person has not validly consented to the confinement in question, and (c) the deprivation of liberty must be one for which the State is responsible: see <u>Storck v Germany,</u>

When determining whether the circumstances amount objectively to a deprivation of liberty, as opposed to a mere restriction of liberty, the court looks first at the concrete situation in which the individual finds herself, taking account of a whole range of criteria, including the type, duration, effects and manner of implementation of the measure in question, bearing in mind that the difference between deprivation, and restriction upon liberty is merely one of degree or intensity and not one of nature or substance…

At a more practical level, guidance as to the objective element is given in the Deprivation of Liberty Safeguards Code of Practice 2008. Chapter 2 of the Code is

entitled: "What is a deprivation of liberty?" At paragraph 2.5, there is what is described as a 'non-exhaustive' list of factors pointing towards there being a deprivation of liberty....

The court must also have regard to the following factors identified in the recent case law…

> *(5) the extent to which it can be said that the managers of the establishment, exercise complete and effective control over the person in his treatment, care, residence and movement: see the judgments of the European Court in DD v Lithuania and Kedzior v Poland, "*[2]

The most important cases some of which are referred to above include:

- R v Bournewood Community & Mental Health NHS Trust (ex parte L) [1998] 3 WLR 107 or HL v UK [2005] 40 EHRR 32.
- Storck v Germany (61603/00) [2005] 1 MHLR 211
- JE v (1) DE (2) Surrey County Council (3) EW [2006] EWHC 3459 (Fam)
- Stanev v Bulgaria 36760/06 [2012] ECHR 46
- DD v Lithuania [2012] ECHR 254 (13469/06)
- Sykora v Czech Republic [2012] ECHR 1960
- Kedzior v Poland [2012] ECHR 1809 (45026/07).
- CC v KK [2012] EWHC 2136 (COP)
- Mihailovs v Latvia [2013] ECHR 65 (35939/10)
- P (by his litigation friend the Official Solicitor) v Cheshire West and Chester Council and another: P & Q (by their litigation friend the Official Solicitor) v Surrey County Council [2014] UKSC 19

[2] A PCT v LDV, CC & B Healthcare Group [2013] EWHC 272 (Fam) www.39essex.com/court_of_protection/browse.php?id=3148 accessed 25 April 2013

Summaries or complete transcripts of all of the above cases are available on the internet. Try the British and Irish Legal Information Institute (BAILII)[3] in the first instance or simply input the case name or reference into a search engine.

Reflective questions

Are you working with someone who is under continuous supervision and control?

What are the factors that lead you to believe this?

[3] www.bailii.org

DoLS apply:

- Aged 18 and over
- Lack the capacity to give informed consent to the arrangements made for their care AND
- for whom deprivation of liberty is considered after an independent assessment to be necessary in their best interests to protect them from harm
- Safeguards cover people in hospital and care homes registered under the Health and Social Care Act 2008 – whether placed publicly or privately.

The Deprivation of Liberty Safeguards were introduced following consultation by government as an answer to the European Court's criticisms in HL. They were introduced into the Mental Capacity Act 2005 by the Mental Health Act 2007, the legislation which amended the Mental Health Act 1983. The Safeguards are an integral part of the MCA and all of the principles of that Act apply to DoLS.

Whereas the Act applies in the most part to over 16's DoLS only applies to people over 18 who lack the capacity to give informed consent to the arrangements made for their care and treatment where those arrangements might amount to a deprivation of liberty. The arrangements have to be in the person's best interests and have to have the intention of protecting the person from harm.

The Safeguards only apply in hospitals and care facilities which are registered under the Health and Social Care Act 2008. They do not apply in people's private homes where any suspected deprivation of liberty, not otherwise authorised by a court, would be a safeguarding issue.

The Managing Authority and Supervisory Body

If hospital or care home (Managing Authority) identifies a person who is being or is at risk of deprivation of liberty, they must apply to the Local Authority (Supervisory Body) for authorisation.

DoLS introduces some new 'bodies' and acronyms including 'MA' and 'SB'. The MA or Managing Authority is the care provider, the hospital or care home where the person is or is likely to be at risk of deprivation of liberty. The SB or Supervisory Body is the organisation which will actually authorise the process.

Questions

Who is your Supervisory Body?

How do authorisations actually happen?

The MA is responsible for identifying people who they are providing care for where they may be doing this in circumstances which amount to a deprivation of liberty, known as the 'Relevant Person'. ('A' on the flow chart below.) They then apply to the SB who commissions the assessments and provides or refuses an authorisation as appropriate. ('B' on the flow chart below.)

Duties of Hospitals and Care Homes

Hospitals and care homes MUST:

- Take all practical steps to explain authorization and how to request a review or appeal, to both personal and representative
- Ensure any conditions are met
- Monitor persons circumstances
- Trigger a review if circumstances change

Hospitals and care homes MAY:

- Request further authorization on expiry

Assuming an authorisation has been found to be appropriate and has been given, the MA has certain responsibilities to meet as outlined above. Details regarding reviews, appeals and representatives will be discussed later in this work book.

Deprivation of Liberty Safeguards Assessors

- Supervisory body selects assessors
- Must be at least two assessors
- Mental health and best interest assessors must be different people
- Regulations re: who can be assessors/qualifications
- All assessors, except the age assessor, should have undertaken appropriate training

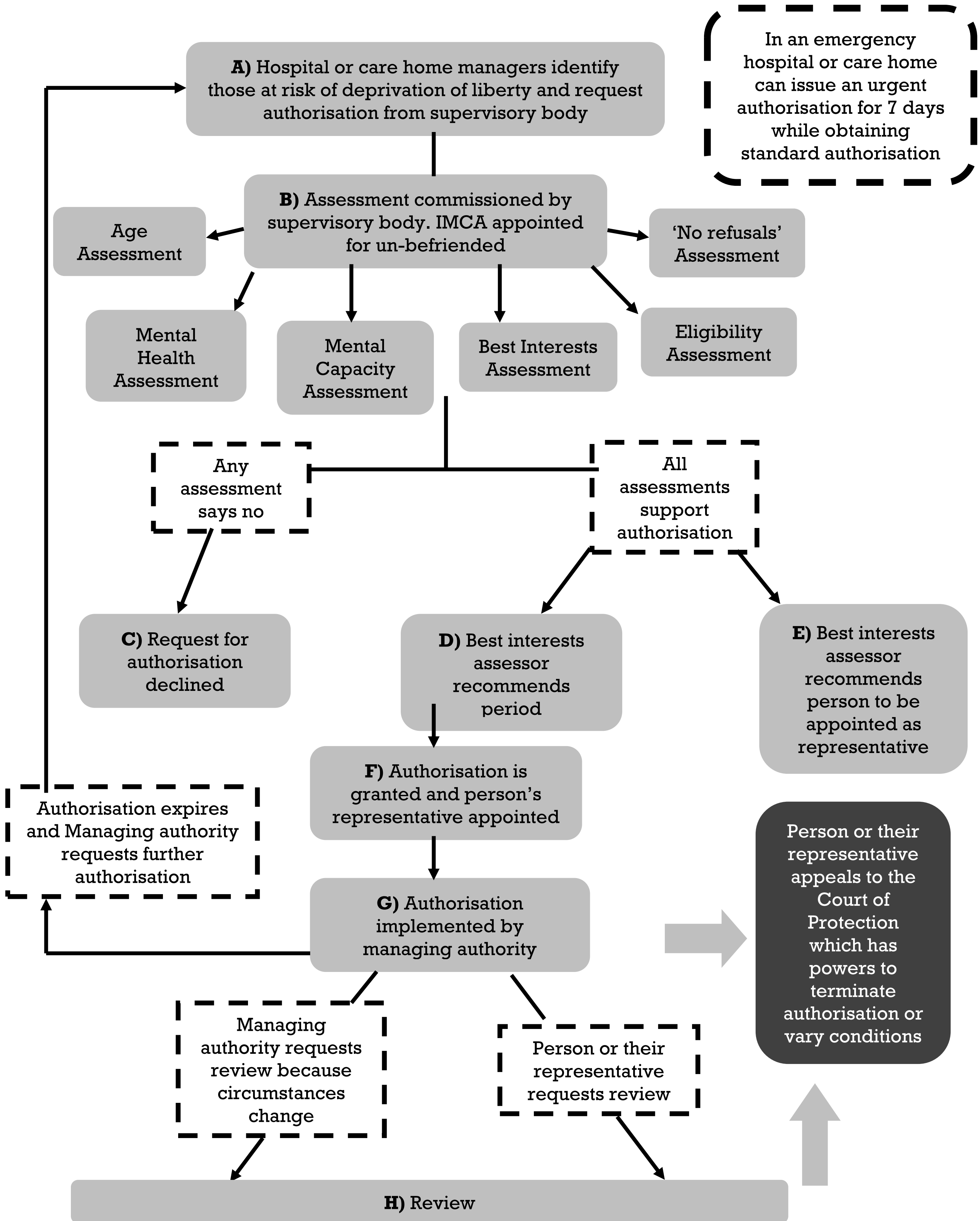
Once the MA requests an authorisation, the SB is responsible for commissioning the assessments. There are six assessments to be undertaken as part of the process as outlined on the flow chart below and in greater detail over the next few pages.

The six assessments have to be completed by a minimum of two different assessors as a doctor has to under take at least one part of the assessment and doctors cannot be 'Best Interest Assessors' (BIA).

Official regulations set out the requirements that professionals need to meet in order to undertake assessments under DoLS.

The six assessments are: age; mental health, mental capacity, best interest, eligibility and no refusals. The assessment process must be completed within 21 calendar days from referral except in certain circumstances.

If it has serious concerns that it is depriving someone of their liberty against their rights under Article 5, the MA can issue itself an urgent authorisation which instantly means that any actual deprivation is legally authorised. At the same time as issuing this authorisation, the MA must request a standard authorisation from the SB. In this case the assessment for a standard authorisation has to be fully completed before the urgent authorisation runs out. In extreme situations the SB can extend the urgent authorisation for up to a further 7 days but the Code of Practice suggests that urgent authorisations and extensions should not become routine and should only be applied in truly extreme circumstances.


In an emergency hospital or care home can issue an urgent authorisation for 7 days while obtaining standard authorisation
A) Hospital or care home managers identify those at risk of deprivation of liberty and request authorisation from supervisory body
B) Assessment commissioned by supervisory body. IMCA appointed for un-befriended
Age Assessment
'No refusals' Assessment
Mental Health Assessment
Mental Capacity Assessment
Best Interests Assessment
Eligibility Assessment
Any assessment says no
All assessments support authorisation
C) Request for authorisation declined
D) Best interests assessor recommends period
E) Best interests assessor recommends person to be appointed as representative
F) Authorisation is granted and person's representative appointed
Authorisation expires and Managing authority requests further authorisation
G) Authorisation implemented by managing authority
Person or their representative appeals to the Court of Protection which has powers to terminate authorisation or vary conditions
Managing authority requests review because circumstances change
Person or their representative requests review
H) Review

Age and Mental Health Assessments

- Age assessment – is the person 18 or over?

  To be undertaken by anybody the supervisory body selects but the Best Interests Assessor is ultimately responsible

- Mental health assessment – is the person suffering from a mental disorder within the meaning of the Mental Health Act and what will be the impact of deprivation of liberty on the person's mental health?

  To be undertaken by a Section 12 approved doctor or doctor with three years post-registration experience in the diagnosis and treatment of mental disorder.

The age assessment seeks to ascertain whether the Relevant Person is over the age of 18 or not. As mentioned above, DoLS only applies to over 18's. In many circumstances this information will be easy to obtain and will be provided by the MA. The Best Interest Assessor is responsible for ensuring the accuracy of the information.

Difficulties may arise, for instance, where the person's age is not immediately obvious. Consider the situation faced by a refugee from the developing world who arrives in this country without any official documents. They may believe they are over 18 but may not be able to prove this.

The mental health assessment seeks to answer two questions; firstly, is the Relevant Person suffering from a mental disorder as defined by the MHA 1983. Within that Act mental disorder is defined as "any disorder or disability of mind".[4] Note the difference between that definition and the MCA phrase "a disturbance of or impairment in the functioning of the mind or the brain." Secondly the assessor is charged with identifying what the likely impact a deprivation of liberty will be on that mental disorder.

This part of the assessment has to be undertaken by a registered medical practitioner, a doctor who is either approved as having specialist knowledge and expertise in the diagnosis and treatment of mental disorder under s12(2) MHA 1983 or who has at least three years post-qualification experience in the diagnosis and treatment of mental disorder. In addition, they have to undertake further specialist training in the DoLS process.

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[4] Mental Health Act 1983 section 1(2)

Mental Capacity and Best Interests Assessments

- Mental capacity assessment – does the personal lack capacity to decide whether or not they should be in the relevant hospital or care home in a care regime that amounts to deprivation of liberty?

  To be undertaken by anybody qualified to be a mental health assessor or Best Interests Assessor

- Best interests assessment – does deprivation of liberty arise and, if so, is it necessary in the person's best interests

  To be undertaken by health and social care professionals who have completed Best Interests Assessor training

The mental capacity assessment seeks to identify whether or not the Relevant Person has the capacity to agree to be in the hospital or care home in circumstances which might amount to a deprivation of liberty. If the person has capacity then there cannot be a deprivation of liberty.

Capacity has to be assessed using the two part diagnostic and functional test for capacity as set out in the MCA 2005. This assessment is undertaken either by the doctor who undertakes the mental health assessment or by the BIA.

The best interest assessment is the cornerstone of the process and is the origin of the name of the BIA. The questions to be answered are "is this actually a deprivation of liberty" and if so "is it in the person's best interest, is it to prevent the person coming to harm and is it a proportionate response to the likelihood and severity of that harm"?

This assessment has to be undertaken by either nurses, social workers, occupational therapists or psychologists who meet certain statutory criteria and who have undergone an accredited programme of training in DoLS, leading to appointment as Best Interest Assessors.

Reflective Question

Do you meet the professional qualifications necessary to undergo training as a BIA?

Would this be a relevant and useful role for you to have?

Eligibility and No Refusals Assessments

- Eligibility assessment – is the person detained under the MHA 1983 or would the authorisation, if given, be inconsistent with an obligation placed on them under the Mental Health Act 1983?

To be undertaken by a doctor approved under s 12(2) MHA 1983 or a Best Interests Assessor who is also an Approved Mental Health Professional.

- No Refusals assessment – has the person made an advance decision which is incompatible with their current situation or does a donee under an LPA or Court Appointed Deputy disagree with the situation P is in?

To be undertaken by the Best Interests Assessor.

The eligibility assessment seeks to identify if the Relevant Person is subject to a provision of the MHA or, if not, whether they should be.

People detained in hospital as an inpatient under the Mental Health Act 1983 are already deprived of their liberty in accordance with their rights under Article 5, ECHR.

This assessment is carried out either by the doctor who undertakes the mental health assessment or by the BIA if the BIA is also qualified as an Approved Mental Health Professional (AMHP) under the MHA 1983

The no refusals assessment seeks to identify whether the person has made a valid and applicable Advance Decision to Refuse Treatment which disagrees with the circumstances the person finds themselves in or whether there is an Attorney or Court Appointed Deputy who otherwise disagrees with the circumstances.

Again, this assessment is likely to draw on information from a number of sources but will be undertaken by the BIA.

Person doesn’t meet all of the criteria

- Authorisation cannot be given
- Any urgent authorisation would end
- Supervisory body informs in writing
    - Person
    - IMCA
    - Care home or hospital
    - All interested personals consulted

The person concerned has to meet all the qualifying criteria before an authorisation can be given. However, not meeting the criteria is not necessarily indicative of poor practice. For instance, assume the person has capacity to agree to be in the situation? Then this would not be a deprivation of liberty assuming they were agreeing and were able to go outside, have visitors, have some control over their lives etc. (‘C’ on the flow chart)

In this instance, there may be no requirement on the MA to make any changes or undertake any particular actions.

However, what if a deprivation of liberty had been identified but the BIA decided it was not in the person’s best interest? In that case an authorisation could not be given and urgent action would need to be taken by the MA in order to ensure that the person was not illegally deprived of their liberty.

If an authorisation cannot be given then the SB has to inform the people concerned in writing.

Whilst DoLS is about safeguarding the rights of vulnerable people, as mentioned above, it is not necessarily about criticising poor practice. The practice in question may very well be a deprivation of liberty but it may also be appropriate, in the Relevant Person’s best interest and proportionate. It could be all of these things and still be a deprivation of liberty. It is at this point that the DoLS process comes into play. An authorisation then allows the MA to deprive the person of their liberty legally with recourse to an appeal process thus bringing the deprivation into line with Article 5, ECHR.

Person meets all of the criteria

- Best Interests Assessor recommends time period
- Best Interests Assessor recommends person to be appointed as Representative and any conditions
- Supervisory body grants the authorization with copies in writing to:
    - Person
    - IMCA
    - Care home or hospital
    - All interested persons consulted
- Supervisory body appoints Representative to keep in touch with the person and support/represent them

Assuming the Relevant Person meets all of the criteria, i.e. they are over 18, they do have a mental disorder as defined by the MHA, they don't have the capacity to agree to stay in the circumstances they are in, it is in their best interests, is to protect them from harm and is proportionate, they are not subject to the MHA and there is no conflicting ADRT or decision of an Attorney or Deputy then the authorisation can be given by the SB on the recommendation of the BIA.

The BIA has to recommend the time period that the authorisation should be in force for. The maximum period that can be recommended is one year. In practice, most recommendations will be for much shorter periods of time. ('D' on the flowchart)

The BIA also has to recommend someone to be appointed as the Relevant Person's Representative. ('E' on the flowchart) More about the role of the Representative later.

If it is satisfied with the assessment the SB grants the authorisation setting the period of time and appoints the Representative. ('F' on the flowchart)

The authorisation is then implemented by the MA ('G' on the flowchart) and the person is deprived of their liberty in accordance with their rights under Article 5(1).

Case Illustration:

Application for standard authorisation
Mrs. Jackson is 87 years old and lives by herself in an isolated bungalow in a rural area. Over the past few years, staff at her local health centre have become increasingly concerned about her wellbeing and ability to look after herself. Her appearance has become unkempt, she does not appear to be eating properly and her house is dirty.

The community mental health team have attempted to gain her trust, but she is unwilling to engage with them. She has refused care workers entry to her home and declined their help with personal hygiene and household chores.

Because it is believed that she is a potential risk to herself, she is admitted to psychiatric hospital under section 2 of the Mental Health Act 1983 for assessment of her mental disorder.

Following the assessment, it is felt that Mrs. Jackson requires further treatment for mental disorder. An application is made for her detention to be continued under section 3 of the Mental Health Act 1983. She is prescribed antipsychotic medication, but this seems to have little effect on her behaviour. She remains extremely suspicious of people to the point of being delusional. She is assessed as potentially having mild dementia, most probably of the Alzheimer type, but because there is no obvious benefit from anti-dementia medication, further treatment for mental disorder is felt unnecessary.

Mrs. Jackson insists that she wishes to return to her own home, but given past failed attempts to gain her acceptance of support at home and her likely future mental deterioration, transfer to a care home is believed to be most appropriate.

A best interests meeting is held by the mental health team to consider her future care and placement, and the team's approved social worker and the instructed IMCA are invited. The meeting concludes that Mrs. Jackson does not have sufficient mental capacity to make an informed decision on her stated wish to return home. There is no advance decision in existence, no Lasting Power of Attorney or court deputy appointed and no practical way of contacting her immediate family.

An appropriate care home is identified. A care plan is developed to give Mrs Jackson as much choice and control over her daily living as possible. However, it is felt that the restrictions still necessary to ensure Mrs Jackson's wellbeing will be so intense and of such duration that they will meet the threshold for the 'acid test' and therefore a request for a standard deprivation of liberty authorisation should be made by the care home manager (the relevant managing authority).

The best interests assessor agrees that the proposed course of action is in Mrs. Jackson’s best interests and recommends a standard authorisation for six months in the first instance.

Independent Mental Capacity Advocates

- Should be instructed in cases where there is no-one appropriate to consult
- Should be instructed urgently if an urgent authorization has been given
- IMCAs instructed re: DoLS have additional rights and responsibilities to those in the main Code of Practice

You will be aware that the MCA has provision for Independent Mental Capacity Advocates. In the main body of the Act, IMCAs have a role to play where the person concerned lacks capacity, is "unbefriended" and a certain decision has to be made in regards to serious medical treatment or certain accommodation decisions. Note that in this case "unbefriended" does not necessarily mean all alone in the world. It can mean that family or friends may not be acting in the best interests of the person. IMCAs can also be used in case reviews and safeguarding procedures.

IMCAs provide a further safeguard for the Relevant Person under the DoLS process and a referral is needed if the person is "unbefriended" ('B' on the flowchart). If the MA have given themselves an Urgent Authorisation then the IMCA referral should be undertaken without delay.

IMCAs instructed under DoLS have to apply the principles of the Act in the same way as other practitioners and have to follow the principles of the advocacy framework they work to but they also have additional responsibilities under DoLS.

Reflective Question

Who provides the IMCA service in your locality?

What is the process for referring someone to the IMCA service?

IMCA Additional Responsibilities

- Give information or make submissions to assessors which assessors must take into account
- Receive copies of assessments from SB
- Receive a copy of standard authorisation given
- Be notified by the SB if a standard authorisation is not given
- Receive a copy of an urgent authorisation from the MA
- Receive a copy of any notice refusing the extension of an urgent authorisation
- Receive a copy of any notice that an urgent authorisation has ended
- Apply to the Court of Protection for permission to take the case to Court in connection with any matter relating to DoLS

IMCAs additional responsibilities are listed above. However, unlike the main body of the Act which states that the use of an IMCA is only appropriate if the person is "unbefriended", DoLS makes provision for IMCAs to assist the Relevant Person and their Representative if requested to do so. This is to provide a further safeguard for the affected participants in using what can seem to be quite a complex process.

Who can be a Representative?

- Over 18
- Able to keep in touch with the person and not prevented by ill-health (physical or mental) from carrying out the role of representative
- Not be employed by or paid for activity at the care home or at the hospital or PCT/LA in which they are or could be involved in the person's case
- Willing
- No financial interest in care depriving personal of liberty

A further safeguard for the Relevant Person in the DoLS process is the appointment of the Representative. Representatives have to meet certain criteria as listed above. This is another area of the MCA where the person exercising the role has to be over 18. In addition they must have no financial interest in the deprivation of liberty. They must also not be employed by the MA.

Representatives must be willing to act as such although there is no expectation that they necessarily agree with the deprivation of liberty. They must be able to keep in touch with the Relevant Person.

Who chooses a Representative?

- Person themselves
- Attorney or Deputy
- Best Interests Assessor
  IF no one eligible among family, friends and carers supervisory body appoints paid representative

In keeping with the guiding principles of the Act and the ethos that people should be encouraged to make their own decisions wherever possible, if the person has the capacity to make the choice and they do choose someone who meets the eligibility criteria listed on the previous page, then that is the person who must be recommended to the SB by the BIA.

If the person doesn't have the capacity to choose but there is an Attorney or Court Appointed Deputy then that person should be asked to nominate someone by the BIA.

If there is no Attorney or Deputy and the person themselves lacks capacity then the BIA should identify a suitable person to be the Representative and recommend that person to the SB.

If the BIA is unable to recommend a suitable candidate who meets the eligibility criteria from within the Relevant Person's family and friends then the SB would need to secure the services of a paid Representative, possibly from the local advocacy provider.

Role of the Representative

- To keep in touch with the person
- To support and help them in matters to do with the authorisation
- Right to trigger a review
- Right to apply to the Court of Protection

The Representative acts as an additional safeguard for the Relevant Person and as such has certain rights and responsibilities.

Primarily the Representative will assist the person to understand the details of the authorisation and the situation they find themselves in. In order to do this it is essential that they are able to keep in regular touch with the person and can monitor the on-going care and treatment process.

If they believe that anything has changed in the person's presentation which might affect any of the assessment criteria which the authorisation is founded on, then they have the right to request a review of the authorisation.

If they are unhappy about aspects of the authorisation, perhaps believing that the conditions are unfair or unreasonable, then they have the right to appeal the case to the Court of Protection.

Review

- Supervisory body must conduct a review if requested by:
    - Hospital or care home
    - Person or representative
    - Donee or deputy
- Review assessments
- May terminate, change reason or change conditions

The Relevant Person's situation and circumstances must be regularly monitored and if any of the circumstances change a Review must be requested and undertaken in order to ensure that the authorisation remains valid.

A Review can be requested by the Managing Authority, the Relevant Person or the Representative or by an Attorney or Court Appointed Deputy if there is one.

Once a change in circumstances has been identified, the SB must commission a fresh look at the criteria which has been identified as being affected by the change of circumstances. It may be, for instance, that the Relevant Person has regained capacity. In that case the mental capacity assessment would be redone and if capacity is proven then the authorisation would have to end as one of the criteria would no longer be met.

Case Illustration:

The review process

Jo is 29 and sustained severe brain damage in a road traffic collision that killed her parents. She has great difficulty in verbal and written communication. Jo can get very frustrated and has been known to lash out at other people in the nursing care home where she now lives. At first, she regularly attempted to leave the home, but the view of the organisation providing Jo's care was that such a move would place her at serious risk, so she should be prevented from leaving.

Jo was assessed under the deprivation of liberty safeguards and an authorisation was made for six months. That authorisation is not due to end for another three months. However, Jo has made huge progress at the home and her representative is no longer sure that the restrictions are necessary. Care home staff, however, do not think that her improvement reduces the best interests requirement of the deprivation of liberty authorisation.

Jo is assisted by her representative to request a review, in the form of a letter with pictures. The pictures appear to describe Jo's frustration with the legal processes that she perceives are preventing her from moving into her own accommodation.

The supervisory body appoints a best interests assessor to coordinate the review. The best interests assessor considers which of the qualifying requirements needs to be reviewed and by whom. It appears that the best interests assessment, as well as possibly the mental health and mental capacity assessments, should be reviewed.

To assess Jo's mental capacity and her own wishes for the best interests assessment, the best interests assessor feels that specialist help would be beneficial. A speech and language therapist meets with Jo and uses a visual communication system with her. Using this system, the therapist is able to say that in her view Jo is unlikely to have capacity to make the decision to leave the care home. The mental health assessment also confirmed that Jo was still considered to have a mental disorder.

The best interests assessor was uncertain, however, whether it was still in Jo's best interests to remain under the deprivation of liberty authorisation.

It was not possible to coordinate full updated assessments from the rehabilitation team, who knew her well, in the time limits required. So, because the care home believed that the standard authorisation was still required, and it was a complex case, the best interests assessor recommended to the supervisory body that two conditions should be applied to the standard authorisation:

▪ Assessments must be carried out by rehabilitation specialists on Jo's clinical progress, and
▪ A full case review should be held within one month.

At this review meeting, to which Jo's representative and the best interests assessor were invited, it was agreed that Jo had made such good progress that deprivation of liberty was no longer necessary, because the risks of her having increased freedom had reduced. The standard authorisation was therefore terminated, and a new care plan was prepared which focused on working towards more independent living.

According to the outcome of the review the SB has a number of options open to it. If the review has not highlighted a change of circumstances then it may not be necessary to do anything at all. Alternatively, the SB could terminate the authorisation, change the reason for which the authorisation has been given or change or remove existing conditions or add in new ones.

Case Illustration:

Fluctuating capacity

Walter, an older man with severe depression, is admitted to hospital from a care home. He seems confused and bewildered, but does not object. His family are unable to look after him at home, but they would prefer him to go into a different care home rather than stay in hospital. However, there is no alternative placement available, so when the assessment concludes that Walter lacks capacity to make decisions about his care and treatment, the only option seems to be that he should stay on the ward.

Because the care regime in the ward is extremely restrictive – Walter is not allowed to leave the hospital and his movement within the hospital is restricted for his own safety – ward staff think that they need to apply for a deprivation of liberty authorisation which is subsequently given. However, over time Walter starts to experience lucid passages, during which he expresses relief at being on the ward rather than in the care home. A review meeting is convened and the participants agree that Walter now sometimes has capacity to make decisions about the arrangements made for his care and treatment. As this capacity fluctuates, it is decided, in consultation with his family, that the deprivation of liberty authorisation should remain in place for the time being.

Walter remains on the ward and his progress is such that his family feel they could look after him at home. Walter seems happy with this proposal and the consultant psychiatrist with responsibility for his care agrees to this. The deprivation of liberty authorisation is reviewed and terminated.

Appeal

- During a standard authorisation – right of appeal to Court of Protection at any time for:
  - Person or their representative
  - Donee or deputy

- Any other person can apply to the Court of Protection for permission to take a case

- During an urgent authorisation – right of appeal to the Court of Protection for the personal and any other person can apply for permission to take a case

The Relevant Person and/or their Representative may not always be happy with the authorisation, the circumstances within which it given or the conditions applicable to it. If a standard authorisation is in place, they have an absolute right of appeal to the Court of Protection at any time. In addition, an Attorney or Court Appointed Deputy also has the absolute right of appeal.

Any other person, including representatives of the Managing Authority or Supervisory Body has the right to ask the Court of Protection if it will hear their appeal. The Court retains the right to refuse another person's appeal.

If the Relevant Person is subject to an urgent authorisation given by the MA then the only person who has an absolute right of appeal is the Relevant Person themselves although any other person can ask the Court for permission to take a case.

The Court of Protection has the power to terminate any authorisation in place, change or remove any existing conditions or add new conditions to the authorisation.

This right of appeal makes the DoLS process compliant with Article 5(4) ECHR.

Key points

- The Deprivation of Liberty Safeguards are in addition to and do not replace other safeguards in the MCA
- DoLS is for the purpose of providing treatment or care under MCA 2005 but does not authorise it
- Essential that hospital and care home managers understand the distinction between **deprivation** and **restriction** of liberty
- Every effort should be made to avoid instituting deprivation of liberty care regimes wherever possible

It is essential to remember that DoLS is an integral part of the Mental Capacity Act 2005 and does not stand alone. As such, all the principles of the Act apply, starting with the primary principle that adults are deemed to have capacity to make their own decisions unless practitioners can prove otherwise. Safeguards set out in the Act, including the best interests checklist and offences under section 44 apply equally to DoLS.

Unlike the Mental Health Act 1983, DoLS does not authorise treatment. As we have seen previously, practitioners will be protected from liability in connection with care or treatment if they follow the principles of the Act and act under section 5. Clear and detailed recording in this instance is crucial.

DoLS as a process can only work if practitioners can identify people they are working with as being either deprived of their liberty or at risk of being. Staff working particularly in primary care, visiting patients in care homes for instance, will be particularly pivotal to this. Any concerns staff have should be discussed with the MA as a matter of urgency.

In an ideal world we wouldn't need a DoLS process at all. And indeed, Managing Authorities and practitioners who are responsible for admitting people to hospital, securing residential care or otherwise providing care and treatment should be doing everything they possibly can to avoid depriving people of their liberty contra to Article 5 ECHR in the first place.

Avoiding Deprivation of Liberty

- Adherence to the principles of the MCA 2005
- Person centred care
- Care planning in partnership with the person, their carers, relatives and other interested parties
- Minimise restrictions
- Review care plans frequently
- Maximise independence and autonomy for the person

It may be impossible in some circumstances to provide care and treatment in any circumstances without depriving the person of their liberty. As mentioned elsewhere, the care plan may very well be appropriate and a less restrictive alternative but might still amount to a deprivation of liberty. But there are steps that can be taken to minimise the risks.

The MCA is founded with the idea of enabling decision making on behalf of persons who are unable to make their own. In order to achieve this, there are a number of safeguards built into the Act, not least the principles. Applying those safeguards will go some way to avoiding the need for DoLS.

We talk a lot in health and social care about person centred care. The talking needs to stop and practitioners need to actually start practising in this way. Good quality, detailed care planning is essential to the process and a good care plan, developed and written in conjunction with the patient, family, friends and carers is crucial. However, a good care plan is of no use whatsoever if it is placed in a folder after completion and only seen by people at reviews. Care plans should be living documents, changeable as people's needs and circumstances change. Care plans should be reviewed at regular and frequent intervals.

Reflective Questions

How much are you involved in the care planning process in hospitals and care homes?

How will you use your knowledge of DoLS to ensure that wherever possible, people you're working with aren't at risk of being deprived of their liberty?

Restrictions that people are under should be kept to an absolute minimum. By doing this, it is likely that the person's independence and autonomy will be maximised, thus lessening the potential for a deprivation of liberty.

Monitoring DoLS

- The Care Quality Commission (CQC)is responsible for monitoring the use of DoLS
- Managing Authorities must notify the CQC when they submit an application for an authorisation and again when the outcome of that application is known.

The Care Quality Commission (CQC) has a number of powers and priorities including regulating health and adult social care services to make sure services are high quality and safe, encouraging improvement and stamping out bad practice; protecting the rights of people who use services, particularly the most vulnerable and those held under the Mental Health Act; providing accessible, trustworthy information on the quality of care and services so people can make better-informed decisions about their care and so that those who arrange and provide services can improve them; and reporting to the public on how commissioners and providers of services are improving the quality of care and providing value for money.

Managing Authorities have to inform CQC when they apply for a DoLS authorisation and again once the outcome is known, partly to prevent MAs giving themselves an Urgent Authorisation and then not telling anyone about it.

Further information about the Care Quality Commission can be found at http://www.cqc.org.uk

Comments from Service Users

"I'm still me. My memory may not be as good as it was but it doesn't stop me from being me"

"You need to focus on the ability and contribution that we can make rather than on what we can no longer do"

"Don't just tell me what to do. Help me make choice"

"You must listen to us much more"

(Strengthening the Involvement of People with Dementia: A resource for implementation of CSIP National Older Peoples HM Programme November 2007)

Working in health and social care can often be a demanding and stressful job. Practitioners have to juggle many different and possibly conflicting demands. How can we practice in a holistic, ethical way if our practice is guided by the amount of resources at our disposal? Can we be truly client centred? Can we honestly be providing needs led care?

Whatever the answers to these questions and whatever our demands it is crucial that we never lose sight of the focus of our jobs in the first place. That focus has to be the person we are providing care and treatment for. It is fitting that the final word in this workbook should be theirs.

QUIZ

Only one answer is correct. Put a tick in the relevant box.

1. Deprivation of Liberty Safeguards cover:

☐ a) Anyone over the age of 16
☐ b) Anyone over the age of 18
☐ c) Anyone from 0 – death
☐ d) Anyone over the age of 21

2. Deprivation of Liberty Safeguards are underpinned by?

☐ a) Nearest Relative guidelines from the Mental Health Act
☐ b) Mental Capacity Act guiding principles
☐ c) Article 8 of the European Convention of Human Rights (Right to a private and family life)
☐ d) FACS

3. Which of these is the name of an authorisation under DoLS

☐ a) Emergency
☐ b) Initial
☐ c) Immediate
☐ d) Urgent

4. How many assessments make up the process under DoLS?

☐ a) 2
☐ b) 4
☐ c) 6
☐ d) 8

5. Which of these is not as assessment in the DoLS process?

☐ a) Mental Capacity
☐ b) No Refusals
☐ c) Eligibility
☐ d) Financial

6. Who gives authorisation for an Urgent Authorisation?

☐ a) Supervisory Body
☐ b) Managing Authority

☐ c) Court of Protection
☐ d) CQC

7. What does CQC stand for

☐ a) Care Questioning Commission
☐ b) Community Quality Centre
☐ c) Care Quality Centre
☐ d) Care Quality Commission

8. How many people at the least carry out the assessments?

☐ a) 1
☐ b) 2
☐ c) 3
☐ d) 4

9. When should a person's Representative be appointed?

☐ a) As soon as a request for an assessment is received
☐ b) Once it has been identified that a DoL may be occurring
☐ c) When a standard authorisation is given
☐ d) After the first review

10. What is the longest time a standard authorisation can be given for?

☐ a) 1 month
☐ b) 6 months
☐ c) 1 year
☐ d) 2 years

11. The Best Interest Assessment

☐ a) Must take into account harm to others
☐ b) Must take into account harm to self and others
☐ c) Must take into account harm to self
☐ d) Does not consider harm

12. It is illegal:

☐ a) To restrict someone's movement
☐ b) To deprive someone of their liberty
☐ c) To deprive someone of their liberty without a procedure prescribed by law
☐ d) To restrict someone's movement without a procedure prescribed by law

The answers to the quiz are available at
http://www.ncpqsw.com/mcworkbook/

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