THE DEPRIVATION OF LIBERTY SAFEGUARDS

1.1 The Mental Capacity Act 2005 was amended by the Mental Health Act 2007 to introduce a new legal framework for depriving people of their liberty. This framework is known as "the deprivation of liberty safeguards" and it enables people who lack capacity to consent to the arrangements made for their care or treatment, to be deprived of their liberty in a care home or a hospital if it is considered necessary in their best interests.

1.2 A supplement to the Mental Capacity Act 2005 Code of Practice, which covers the deprivation of liberty safeguards, provides guidance and information about how the framework should operate in practice (the DOL Code of Practice).[1] As is the case for the main Mental Capacity Act Code of Practice, certain categories of people are required to have regard to the relevant guidance in the DOL Code of Practice, including anyone acting in a professional capacity.

Background

1.3 The deprivation of liberty safeguards were introduced as a result of a legal case, known as the "Bournewood case" or "HL v UK". This concerned an autistic man (known as 'HL') with a learning disability, who lacked the capacity to consent to, or to refuse, admission to hospital for treatment.

1.4 In July 1999, HL was admitted to Bournewood Hospital for assessment and treatment of a mental disorder. Since he did not object or resist to the admission, HL was not detained under the Mental Health Act 1983 but was admitted informally in his best interests, in accordance with the common law doctrine of necessity. This was common practice at the time.

1.5 HL remained in hospital for several weeks and was prevented from leaving and denied access to his carers.

1.6 HL's carers, who had objected to the admission, brought legal proceedings against the hospital managers on the grounds of unlawful detention. This went through the appeal courts to the House of Lords, and then to the European Court of Human Rights.

1.7 In 2004 the European Court of Human Rights reached the following conclusions:

[1] Avialble for download at:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085476?IdcService=GET_FILE&dID=167082&Rendition=Web

(1) HL had been deprived of his liberty when he had been admitted informally to hospital;

(2) His informal admission had not been in accordance with "a procedure prescribed by law" and was therefore in breach of Article 5(1) of the European Convention on Human Rights (ECHR); and

(3) There had also been a breach of Article 5(4) of the ECHR because HL was not able to apply to a court quickly to see if his deprivation of liberty was lawful.

1.8 To prevent similar breaches of the ECHR, the deprivation of liberty safeguards were introduced for people such as HL, who lack decision making capacity and who need to be deprived of their liberty in order to provide care and treatment, but who cannot be detained under the Mental Health Act 1983. The safeguards were implemented in April 2009.

Where can deprivations of liberty take place?

1.9 Although the Bournewood case was about a patient who was admitted to a psychiatric hospital, the judgment has wider implications that extend to people who lack capacity and need to be deprived of liberty but do not require hospital treatment. The safeguards therefore apply to all hospitals (including acute hospitals and psychiatric hospitals) and care homes. The safeguards also apply regardless of whether the care or treatment has been publicly or privately arranged.

1.10 The deprivation of liberty safeguards do not, however, apply to people living in their own home or in supported living arrangements other than a care home. In these cases, a deprivation of liberty could only be ordered by the Court of Protection.

What is a deprivation of liberty?

1.11 The question of whether a person has been, or is likely to be, deprived of their liberty is not straightforward, as the judgments of numerous legal cases (including the Bournewood case) demonstrate.

1.12 The judgment in the Bournewood case made it clear that the starting point must be the concrete situation of the individual concerned and account must be taken of a whole range of criteria such as the type, duration, effects and manner of implementation of the measure(s) in question.

1.13 There is a distinction in law between:

(1) a **deprivation of liberty**, which is unlawful unless authorised; and

(2) a **restriction of liberty**, which is lawful if carried out in accordance with the Mental Capacity Act.

1.14 However this distinction is merely one of degree or intensity and not one of nature or substance.

1.15 Chapter 2 of the DOL Code of Practice provides practical guidance and examples from case law of what constitutes a deprivation of liberty. It also provides practical steps that can be taken to reduce the risk of a deprivation of liberty occurring.

Who can be deprived of their liberty?

1.16 The deprivation of liberty safeguards apply in England and Wales to people aged 18 and over, who:

(1) are suffering from a mental disorder;

(2) lack capacity to consent to the arrangements made for their care or treatment; and

(3) need to be given care and treatment in circumstances that amount to a deprivation of liberty in a hospital or a care home, where this care and treatment is necessary to protect them from harm and is in their "best interests" as defined in section 4 of the Mental Capacity Act 2005 .

Authorisations for deprivations of liberty

1.17 The deprivation of liberty safeguards provides two mechanisms for depriving a person of their liberty: 'standard authorisations' and 'urgent authorisations'.

Standard authorisations

1.18 In most cases, a standard authorisation must be obtained before a person can be deprived of their liberty.

THE PROCEDURE

1.19 The procedure for obtaining this can be summarised as follows:

(1) The relevant hospital or care home (known as "the managing authority") must complete an application for a standard application when it appears likely that, at some point during the next 28 days, someone will need to be deprived of their liberty in order to be provided with care or treatment.

(2) The application must be sent to the appropriate "supervisory body". This will be:

(a) the commissioning primary care trust (for hospitals in England);

(b) the Welsh Ministers or local health board (for hospitals in Wales); or

(c) local authority (for care homes in England and Wales).

(3) The supervisory body must then appoint a minimum of two independent assessors (one of whom must be a doctor with experience in mental disorder) to assess whether the criteria for a deprivation of liberty are satisfied (see below).

(4) If the assessments conclude that the person meets the criteria, then the supervisory body must issue a standard authorisation for a deprivation of liberty. This can last up to 12 months. The length of a standard authorisation is decided by the best interests assessor (see below).

THE CRITERIA

1.20 A standard authorisation can only be issued if a series of six assessments indicates the need to do so. These must be completed within 21 days, starting from the date on which the supervisory body receives the request from the managing authority, or in Wales, 21 days starting from the date that the assessors were instructed by the supervisory body.

1.21 The six assessments are as follows:

(1) **The age assessment:** this assessment must confirm that the person is aged 18 or over. It can be undertaken by anyone who is eligible to be a best interests assessor (see below).

(2) **The Mental Health Assessment:** This assessment must establish whether the relevant person is suffering from a mental disorder within the meaning of the Mental Health Act 1983 but disregarding the exclusion for learning disability. This means any disorder or disability of the mind (including all learning disabilities) but not including dependence on alcohol or drugs.

This assessment must be carried out by a doctor who is approved under section 12 of the Mental Health Act 1983 or has at least three years post-registration experience in the diagnosis and treatment of mental disorder. In England, the doctors must also have completed the standard training for deprivation of liberty mental health assessors.

(3) **The Mental Capacity Assessment:** This assessment must establish whether the person lacks the relevant decision making capacity. For a standard authorisation to be issued, the person must lack capacity to decide whether or not to be accommodated in the relevant hospital or care home for the purpose of being given the relevant care or treatment. An assessment must be made of the person's capacity to make this decision at the time it needs to be taken. The mental capacity assessment can be undertaken by anyone who is eligible to be mental health or best interests assessor (see below).

(4) **The Best Interests Assessment:** The best interests assessment must establish whether:

(a) A deprivation of liberty is occurring, or going to occur;

(b) It is in the best interests of the relevant person to be deprived of liberty;

(c) A deprivation of liberty is necessary to prevent harm to the relevant person; and

(d) It is a necessary and proportionate response to the likelihood of the person suffering harm and the seriousness of that harm, for the person to be deprived of liberty.

The best interests assessor must be an Approved Mental Health Professional, a social worker, nurse, occupational therapist or psychologist, who the supervisory body is satisfied has the necessary skills and experience to carry out this role.

The best interests assessor can be an employee of the supervisory body or managing authority but cannot be involved in the care or treatment of the person being assessed.

(5) **The Eligibility Requirement:** The purpose of this assessment is to ensure that the relevant person cannot be dealt with more appropriately under the Mental Health Act 1983. In order to satisfy this requirement, the assessor must establish that:

(a) the person is not detained in hospital under the Mental Health Act 1983;

(b) the authorisation does not conflict with an obligation placed on the person by leave of absence, guardianship, Supervised Community Treatment or conditional discharge, such as a requirement to live somewhere else; and

(c) the person could not be more appropriately detained under the Mental Health Act 1983. A standard authorisation could not be given to deprive someone of their liberty in a hospital for the purpose of treatment for a mental disorder, in circumstances where the Mental Health Act 1983 could be used – for example, if the person objects to deprivation of liberty, or is likely to object, and they meet the critieria for detention under section 2 or section 3 of the Mental Health Act 1983.

The eligibility assessment must be carried out by a doctor who is approved under section 12 of the Mental Health Act 1983 or by a best interests assessor who is also an Approved Mental Health Professional.

(6) **The no refusals assessment:** The purpose of this assessment is to establish whether the standard authorisation would conflict with other decision-making authority for that person. The assessor must therefore ensure that the deprivation of liberty is not inconsistent with a valid advance directive or any decision made by their donee under a Lasting Power of Attorney or deputy appointed by the Court of Protection.

This assessment can be undertaken by anyone who is eligible to be a best interests assessor.

1.22 If each of the six assessments come to the conclusion that the relevant person meets the qualifying requirement to which the assessment relates, then the supervisory authority must give a standard authorisation.

CONSIDERATIONS FOR SUPERVISORY BODIES WHEN APPOINTING ASSESSORS

1.23 There must be a minimum of two assessors. The mental health requirement and the best interests requirement must be assessed by different people.

1.24 None of the assessors should have a financial interest in the case of the person being assessed nor can they be a relative of the person being assessed.

1.25 The DOL Code of Practice also recommends that the supervisory body should seek to avoid appointing assessors in any conflict of interests situations that might bring into question their objectivity. It also suggestions that knowledge of the experience of working with the same service user client group and people from the same cultural background as the person being assessed, may be relevant considerations when appointing assessors.[2]

CONDITIONS

1.26 The best interests assessor may recommend conditions that should be attached to the standard authorisation. The supervisory body must then decide which conditions, if any, will apply and the managing authority must ensure they are complied with. For example, the conditions may specify who the relevant person should have contact with, when they can go out, which behaviours are prohibited and any other issues related to the deprivation of liberty. The DOL Code of Practice recommends that any conditions must relate directly to the deprivation of liberty and should aim to impose the minimum necessary restraints.[3]

FORM OF AUTHORISATION

1.27 A standard authorisation must be in writing and must state the following:

(1) the name of the relevant person;

(2) the name of the relevant hospital or care home;

(3) the period during which the authorisation is to be in force;

(4) the purpose for which the authorisation is given;

(5) any conditions subject to which the authorisation is given; and

(6) the reason why each qualifying requirement is met.

[2] Ministry of Justice and Department of Health, Mental Capacity Act 2005 Deprivation of Liberty Safeguards (2008) paras 4.13 to 4.14.

[3] Ministry of Justice and Department of Health, Mental Capacity Act 2005 Deprivation of Liberty Safeguards (2008) paras 4.74 to 4.75.

Urgent Authorisations

1.28 If it is not possible to obtain a standard authorisation, and the managing authority believes it is necessary to deprive a person of their liberty in their best interests before the standard authorisation process can be completed, then an urgent authorisation can be completed.

CRITERIA

1.29 In order to issue an urgent authorisation, the managing authority must:

(1) have made a request for a standard authorisation, or be required to make such a request; and

(2) believe that the need for the relevant person to be deprived of liberty is so urgent that it is appropriate for the detention to begin before the request is disposed of, or before they make the request.

1.30 The DOL Code of Practice is clear that an urgent authorisation should not be used where there is no expectation that a standard deprivation of liberty authorisation will be needed and where an urgent authorisation is being used simply to legitimise a short term deprivation of liberty. Similarly an urgent authorisation should not be used, for example, in an accident and emergency department or a care home where it is anticipated that in a short period of time the person will no longer be in that environment.[4]

EFFECT OF AN URGENT AUTHORISATION

1.31 This enables the hospital or care home managers to authorise themselves to deprive a person of liberty for up to seven days, pending the completion of the standard authorisation assessment. The supervising body can extend this for a further seven days whilst the standard authorisation assessments are carried out.

1.32 The managing authority decides the period for which the urgent authorisation is given but it must not exceed seven days. In exceptional cases this can be extended to a maximum of 14 days by the supervisory body.

FORM OF THE URGENT AUTHORISATION

1.33 An urgent authorisation must be in writing and must state the following things:

(1) the name of the relevant person;

(2) the name of the relevant hospital or care home;

(3) the period during which the authorisation is to be in force;

(4) the purpose for which the authorisation is given.

[4] Ministry of Justice and Department of Health, Mental Capacity Act 2005 Deprivation of Liberty Safeguards (2008) paras 6.3 to 6.4.

Representatives & advocates

1.34 Once a standard authorisation has been given, the supervisory body must appoint a representative for the person being deprived of liberty.

Role of the representative

1.35 The role of the representative is to maintain contact with the person and to represent and support them in matters relating to the standard authorisation. The representative has a right to require a review to be held, use the complaints procedure or appeal to the Court of Protection on the person's behalf.

Who can be a representative?

1.36 A representative can be chosen by:

(1) the person being deprived of their liberty, if they have capacity to make that choice;

(2) their donee under a Lasting power of Attorney or deputy appointed by the Court of Protection, in cases where these powers are relevant; or

(3) the best interests assessor or the supervisory body.

1.37 The representative must be:

(1) 18 years old or over;

(2) able to keep in contact with the relevant person; and

(3) willing to be appointed.

1.38 The representative cannot:

(1) have a financial interest in the managing authority, or be a relative of someone who has a financial interest;

(2) be employed by the care home where the relevant person is living, or be involved in providing services to the care home;

(3) be employed by the hospital where the relevant person has been admitted and involved in their care and treatment; or

(4) employed by the supervisory body to work in a role related to the relevant person's care.

1.39 Where there is no representative, the supervisory body must appoint an Independent Mental Capacity Advocate to undertake the function.

Role of the Independent Mental Capacity Advocate (IMCA)

1.40 Both the person who is deprived of liberty and their representative have a right to access an IMCA. The role of the IMCA is to help represent the relevant person and assist them, and their representative, to understand the authorisation and how to challenge it. The IMCA may also request that the supervisory body should review any of the qualifying criteria.

Duties to give information

1.41 Where a standard authorisation is given, the supervisory body must give a copy of the authorisation to:

(1) the relevant person's representative;

(2) the managing authority of the relevant hospital or care home;

(3) the relevant person;

(4) any section 39A IMCA;

(5) every interested person consulted by the best interests assessor.

1.42 Where a standard authorisation is not made following a request, the supervisory body must give notice to each of the following—

(1) the managing authority of the relevant hospital or care home;

(2) the relevant person;

(3) any section 39A IMCA;

(4) every interested person consulted by the best interests assessor.

1.43 Where a standard authorisation is given, the managing authority of the relevant hospital or care home must take such steps as are practicable to ensure that the relevant person understands all of the following:

(1) the effect of the authorisation;

(2) the right to make an application to the Court of Protection;

(3) the right to request a review;

(4) the right to have an IMCA appointed;

(5) how to have an IMCA appointed.

1.44 Any written information given to the relevant person must also be given by the managing authority to the relevant person's representative and where applicable their IMCA.

1.45 Where an urgent authorisation is given, the managing authority of the relevant hospital or care home must take such steps as are practicable to ensure that the relevant person understands all of the following:

(1) the effect of the authorisation;

(2) the right to make an application to the Court of Protection.

Consent to treatment

1.46 While a deprivation of liberty authorisation might be given for the purpose of providing treatment, the deprivation of liberty authorisation does not authorise treatment. Any treatment given while the person is subject to a deprivation of liberty authorisation, may only be given with the person's consent (if they have capacity to make this decision) or in accordance with a best interests determination under the wider provisions of the Mental Capacity Act 2005.

1.47 Any treatment given while the person is subject to a deprivation of liberty authorisation is not regulated by Parts 4 and 4A of the Mental Health Act 1983. The only exceptions to this are patients who are subject to Supervised Community Treatment and also under a deprivation of liberty authorisation.

Reviews of the deprivation of liberty

Who can request a review?

1.48 The supervisory body must carry out a review of a standard authorisation if a request is made by:

(1) the person deprived of liberty;

(2) his or her representative, or

(3) the managing authority body – which is also under a duty to monitor the case of any person deprived of liberty, to see if the person's circumstances change. This may indicate the need for a review or discharge.

1.49 The supervisory body can also carry out a review at its own discretion.

Statutory grounds for review

1.50 The grounds for a review are that:

(1) The person no longer meets one of the six requirements for a deprivation of liberty set out above;

(2) As a result of a change in the person's circumstances it is appropriate to make changes to the conditions to which the authorisation is subject; or

(3) The reasons why the person meets the qualifying requirements is different from the reasons given when the standards authorisation was given.

The review process

1.51 Once it receives a request for a review, the supervisory body must decide which of the qualifying requirements need to be reviewed (if any) and arrange for a separate review assessment for each of these.

1.52 If the supervisory body decides that only the conditions attached to the authorisation need to be changed and there is no need for a full reassessment of the best interests condition, it can vary the conditions as appropriate.

1.53 Assessors are allowed to rely upon existing assessments that are no more than a year old.

Outcome of the review

1.54 If any assessment determines that the conditions are not met, the authorisation is terminated immediately. Once it ends, the supervisory body must inform:

(1) the relevant person;

(2) their representative;

(3) the managing authority; and

(4) any other relevant person named by the best interests assessor.

1.55 A deprivation of liberty can end before a formal review takes place. It can be ended immediately for example by changing the care regime. The managing authority would then apply to the supervisory body for a review and, if appropriate, formally terminate the authorisation.

Rights of appeal

1.56 The deprivation of liberty safeguards provide a right to appeal to appeal to the Court of Protection in certain circumstances.

1. Before an authorisation is given

1.57 The relevant person, their representative or a donee of a Lasting Power of Attorney or deputy appointed by the Court of Protection can apply (without permission) to the court before an authorisation has been issued asking it, for example, to determine whether the person has capacity or whether any act done or proposed to be done is lawful. Any other person must seek permission to take the case to court.

2. After a standard authorisation has been given

1.58 The person, their representative or a donee of a Lasting Power of Attorney or deputy has the right to apply to the Court to determine:

(1) Whether the person meets one or more of the qualifying requirements;

(2) The length that the order is to be in force;

(3) The purpose for which the standard authorisation is given; or

(4) The conditions that are attached to the order.

1.59 Any other person must seek permission to take the case to court. The court has the power to vary or terminate the standard authorisation, or direct the supervisory body to vary or terminate the standard authorisation.

3. After an urgent authorisation has been given

1.60 The person, their representative or a donee of a Lasting Power of Attorney or deputy has the right to apply to the Court to determine:

(1) Whether the authorisation should have been given;

(2) The length that the order is to be in force; or

(3) The purpose for which the standard authorisation is given.

1.61 The court has the power to vary or terminate the urgent authorisation, or direct the managing authority to vary or terminate the urgent authorisation.

Unauthorised deprivations of liberty

1.62 If a person believes that they are being deprived on their liberty without an authorisation being issued, or a third party believes that this has occurred, then they can write to the managing authority (using a standard letter) who must respond within 24 hours.

1.63 The person can also approach the supervisory body in cases where they have raised the matter with the managing authority and no application for a deprivation has been made within a reasonable period. In such cases (unless there are good reasons not to do so) the supervisory body must arrange for a best interests assessor to decide whether the person is deprived of liberty. This must be completed within 7 days.

1.64 If the best interests assessor concludes an unauthorised deprivation of liberty is taking place, then the full assessment must be completed as for any other standard authorisation.

1.65 If a person raises concerns about an unauthorised deprivation of liberty with the supervisory body, then the supervisory body must arrange an initial assessment and then, if necessary, ask the managing authority to apply for a standard authorisation.

Section 117 aftercare

1.66 The categories of people eligible to receive aftercare services under section 117 of the Mental Health Act 1983 do not include people who are (or have been) subject to the deprivation of liberty safeguards.

1.67 However, a person who is entitled to section 117 services would not lose that entitlement on the basis that a standard or urgent authorisation had been issued.

Overlap with the Mental Health Act 1983

1.68 There is some overlap between the deprivation of liberty safeguards and the powers under the Mental Health Act 1983. Although the deprivation of liberty safeguards cannot apply to people who are detained in hospital under the Mental Health Act 1983, they may apply where a person is subject to the various community orders under the 1983 Act.

1.69 Where a person is on leave of absence or subject to Supervised Community Treatment, guardianship or conditional discharge, an authorisation for deprivation of liberty can be given as long as this is not inconsistent with an obligation placed on them under the Mental Health Act 1983, for example, a requirement to live somewhere.

1.70 Where the authorisation relates to a deprivation of liberty in a hospital for the purpose of treatment for mental disorder then the person cannot be made subject to the deprivation of liberty safeguards if they object to being admitted to hospital and meet the criteria for detention under the Mental Health Act 1983. In such cases, the DOL Code of Practice suggests that it may be necessary to arrange an assessment to see if the person needs to be detained under the Mental Health Act.[5]

1.71 Where the authorisation relates to a deprivation of liberty in a hospital for the purpose of treatment for mental disorder then the person cannot be made subject to the deprivation of liberty safeguards if they are on leave of absence or subject to Supervised Community Treatment or conditional discharge, where instead the powers of recall under the Mental Health Act can be used.

Criticisms of the Deprivation of liberty safeguards (DOLS)

1.72 As is clear from the above - and as anyone who has attempted to read schedules A1 and 1A to the MCA will testify - the DOLS are overly complex, excessively bureaucratic and often impenetrable. A recent report by the Mental Health Alliance found that widespread misunderstanding and confusion about the legislation has led to the DOLS being "drastically underused" and enormous geographical variation.[6]

1.73 One of the problems is that the DOLS were drafted almost entirely to deal with the Bournewood case – which was a highly unusual case – and case law has developed in different directions since then, meaning that the DOLS struggle to cope with cases that are different in substance to that of the Bournewood case.

1.74 Earlier this year, the Department of Health took the unusual step of issuing a briefing paper on the DOLS to highlight some emerging practice difficulties.[7] The paper points to 125 cases where a person had been deprived of their liberty even though less restrictive options were available, and warns that any such unlawful deprivations of liberty should be ended as swiftly as possible.

[5] Ministry of Justice and Department of Health, Mental Capacity Act 2005 Deprivation of Liberty Safeguards (2008) para 4.56.

[6] Mental Health Alliance, *Deprivation of Liberty Safeguards: An Initial Review of Implementation* (2010).

[7] Department of Health, *The Mental Capacity Act 2005: Deprivation of Liberty safeguards – The Early Picture* (2010).

1.75 It points to examples of professionals not adhering to the Code of Practice by specifying conditions be attached to the DOLS authorisation which do not relate directly to the issue of deprivation of liberty, and by not selecting family members to be the person's representative on the grounds that they have opposed the deprivation of liberty. The paper also reminds professionals that the DOLS should not be relied upon to prevent contact between a person who lacks capacity and another person who presents a risk of harm or abuse, and to manage cases involving ongoing disputes with family members; in both instances the matter must be referred to the Court of Protection.

1.76 The courts have also been critical of the actions or mindset of some local authorities in relation to the DOLS. In *G v E*, the Court of Protection admonished a local authority for its failure to initiate the DOLS process or an application to the court when there was evidence of a deprivation of liberty.[8] This case involved an incapacitated service user who, following a safeguarding alert, had been removed from his home, where he lived with his long-term carer, into a specialist residential unit. The judge ruled that the service user had been unlawfully deprived of liberty and the local authority had made "grievous errors" in not following the DOLS process. No blame was attached to the social worker as she had received a "paucity of training" on the Mental Capacity Act 2005; the responsibility for the "blatant errors" was "higher up the line of management." The judge further held that there had been a "serious breach" of Article 8 of the European Convention on Human Rights in not consulting or involving the carer in the decision making process.

1.77 The clear message from the courts is that the DOLS must be taken seriously by professionals, and it is therefore likely that the numbers of authorisations will increase. While this will ensure that more vulnerable people being deprived of their liberty will receive appropriate safeguards and support, it will also result in more professionals struggling to cope with the complexities and excessive bureaucratisation of the DOLS.

[8] *G v E* [2010] EWHC 621 (Fam).