Mental Capacity Act 2005 - Deprivation of Liberty Safeguards

Extracts from The Code of Practice – to supplement MCA 2005 Code of Practice and Other Guidance

A Guide for Practitioners by a Practitioner

This is a guide for anyone working with people who have an impairment of, or a disturbance in the functioning, of their mind or brain and need care or treatment in a care home or hospital and lack the capacity to consent to that care or treatment. This will affect all members of the MDT including those who will be Best Interests Assessors working with such people because, in the first instance, it will be up to those delivering that care or treatment to decide whether in such cases a deprivation of liberty (hereafter DoL) is occurring. If one is staff in the Managing Authorities (hospitals and care homes) need to apply for an authorisation.

As will be made clear (inasmuch as there is clarity about this issue) this does not mean someone who is locked up, restrained, only allowed out with an escort and treated against their wishes is necessarily being deprived of liberty.

This guide offers extracts from the Deprivation of Liberty Safeguards Code of Practice, the thoughts of Richard Jones and my reflections in enabling us to determine whether a restriction or a deprivation of liberty is occurring. None of this gets practitioners out of having to read the codes of practice (of the main Mental Capacity Act and the DoLS) – professionals working in the area should be familiar with them. In my opinion they are actually quite helpful and accessible and not as long as they first appear.

In order to allow more than a restriction of liberty, schedule A1 (procedures for deprivation of liberty) and 1A (people not eligible for DoL) were introduced to the Mental Capacity Act by the Mental Health Act 2007. Section 6 of the Mental Capacity Act 2005 states that;

"6. Section 5 acts: limitations

(1) If D does an act that is intended to restrain P, it is not an act to which section 5 (i.e. acts in connection with care or treatment) applies unless two further conditions are satisfied.
(2) The first condition is that D reasonably believes that it is necessary to do the act in order to prevent harm to P.
(3) The second is that the act is a proportionate response to –
    (a) the likelihood of P suffering harm, and
    (b) the seriousness of that harm."

Article 5(1) of the Human Rights Convention / Human Rights Act 1998 does not allow deprivation of liberty unless done so within a proper legal framework.

"Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:

(e) the lawful detention of persons…..of unsound mind…"

This addition to our powers to detain people was needed because the Mental Health Act 1983 did not clearly apply to people who lacked capacity – the so called "Bournewood Gap". The government had to address this following the European Court of Human Rights ruling on this case in 2004.

Right at the beginning of the DoLS Code of Practice, it is noted that

"1.5 It is neither necessary nor appropriate to apply for a deprivation of liberty authorisation for everyone who is in hospital or a care home simply because the person concerned lacks capacity to decide whether or not they should be there.

Who is covered by these safeguards?

1.7 ..people in England and Wales who have a mental disorder and lack capacity to consent to the arrangements made for their care or treatment but for whom receiving care or treatment in circumstances that amount to a deprivation of liberty may be necessary TO PROTECT THEM FROM HARM and appears to be in their BEST INTERESTS - *([my capitals] for Approved Mental Health Professionals this is a slight change from grounds for detention under MHA where admission for treatment without risk to self or others would be permissible though in the absence of risk this is now less likely due to pressure on beds)*

1.8 ..The authorisation must relate to the individual concerned and to the hospital or care home in which they are detained.

1.10 ..a deprivation of liberty authorisation does not itself authorise treatment.

1.11 ..The safeguards cannot apply to people while they are detained in hospital under the Mental Health Act 1983 *(as they are legally detained already)*

1.12 The safeguards relate only to people aged 18 and over.

When can someone be deprived or their liberty?

1.13 – in their own best interests to protect them from harm
if it is a proportionate response to the likelihood and seriousness of the harm
and
if there is no less restrictive alternative

1.14 ..(not) for the convenience of professionals or anyone else…..(and)…..due to delays in moving people between care or treatment settings (*although this is, and undoubtedly will continue to be, a real problem - where people are waiting to move out of hospital. I suspect that people might be more likely to be deprived in a general hospital bed than in a residential home with a different philosophy of care centred around encouraging people to go out into the community and move about within the units*)

Where do the safeguards apply?

1.19…..in a hospital or in a care home

1.20. It will only be lawful to deprive someone of their liberty elsewhere (e.g.…in supported living arrangements other than in a care home….) when following an order of the Court of Protection on a personal welfare matter.

What is deprivation of liberty?

What does case law say to date?

2.1. The European Court of Human Rights (ECtHR) has drawn a distinction between the deprivation of liberty of an individual (which is unlawful, unless authorised) and restrictions on the liberty of movement of an individual.

2.2 The distinction between a deprivation of, and restriction upon, liberty is merely one of degree or intensity and not one of nature or substance.

2.5 ..the following factors can be relevant to indentifying whether steps taken involve more than restraint and amount to a deprivation of liberty…..this list is not exclusive;

- Restraint is used, including sedation, to admit a person to an institution where that person is resisting admission
- Staff exercise complete and effective control over the care and movement of a person for a significant (*not defined*) period.
- Staff exercise control over assessments, treatment, contacts and residence.
- A decision has been taken by the institution that the person will not be released into the care of others, or permitted to live elsewhere, unless the staff in the institution consider it appropriate.
- A request by carers for a person to be discharged to their care is refused.
- The person is unable to maintain social contacts because of restrictions placed on their access to other people.
- The person loses autonomy because they are under continuous supervision and control."

Jones in his comments on s131 (informal admission of patients) of the MHA 1983 in the 10th edition of the MHA Manual comes to the following conclusions;

Jones seems to be suggesting we need at least one of these for there to be a deprivation of liberty:

1. Force being used to take a resisting patient to the hospital.
2. The decision to admit the patient to the hospital being opposed by relatives or carers who live with the patient.
3. Force being used to prevent the patient from leaving the hospital in a situation where the patient is making persistent and purposeful attempts to leave.
4. More than benign force being used in a non-emergency situation to ensure that a resisting patient receives necessary treatment for his or her mental disorder.

5 The hospital denying a request by relatives or carers for the patient to be discharged to their care.
6 A decision by the hospital to deny or severely restrict access to the patient by relatives or carers.
7 The patient being denied freedom of association within the hospital, or otherwise being subject to a care regime which severely restricts his or her autonomy.
8 The patient's access to the community being denied or severely restricted primarily due to concerns about public safety.

He then suggests that the following alone would not:

1 Benign force being used to take a confused patient to hospital.
2 The patient being treated in a locked ward.
3 The design of door handles or the use of key pads making it difficult for a confused patient to leave the ward area.
4 Staff bringing the patient who has wandered back to the ward.
5 The use of benign force to feed, dress or provide medical treatment for the patient.
6 The use of restraint, medication or seclusion in an emergency situation in order to respond to the patient's disturbed or threatening behaviour.
7 Dissuading a confused patient from attempting to leave the ward, using benign force if necessary. This would be the case even if the confused patient had attempted to leave the ward on more than one occasion.
8 Placing reasonable limitations on the visiting of the patient by relatives or carers.
9 A refusal to let the patient leave the hospital in the absence of an escort whose role would be to support the patient rather than to protect the public.

My own view is that the man on the street would find this difficult to understand. If someone is stopped from leaving somewhere even if it is in their best interests and they are too confused to understand it then they have been deprived of their liberty.

The Code goes on to offer more guidance.

"What does the Act mean by "restraint"?

2.8 Section 6(4) of the Act states that someone is using restraint if they:
- use force – or threaten to use force – to make someone do something that they are resisting, or
- restrict a person's freedom of movement whether they are resisting or not.

2.9…..Restraint is appropriate when it is used to prevent harm to the person who lacks capacity and it is a proportionate response to the likelihood and seriousness of harm (*the use of the word harm again*). A proportionate use of restraint falls short of deprivation of liberty.

2.10 Preventing a person from leaving a care home or hospital unaccompanied because there is a risk that they would try to cross a road in a dangerous way, for example, is

likely to be seen as a proportionate restriction or restraint to prevent a person from coming to harm…..similarly, locking a door to guard against immediate harm is unlikely, in itself, to amount to a deprivation of liberty.

2.11 The ECtHR has also indicated that the duration of any restrictions is a relevant factor when considering whether or not a person is deprived of their liberty. This suggests that actions that are immediately necessary to prevent harm may not, in themselves, constitute a deprivation of liberty.

2.12…..where the…..restraint is frequent cumulative and ongoing…..then care providers should consider whether this has gone beyond permissible restraint.

How does the use of restraint apply within a hospital or when taking someone to a hospital or a care home?

2.13 "If a person in a hospital for mental health treatment, or being considered for admission for mental health treatment, needs to be restrained, this is likely to indicate that they are objecting to treatment or to being in hospital….(*we*) may wish to consider use of the Mental Health Act 1983"

BUT

2.14 "Even where there is an expectation that the person will be deprived of liberty…..it is unlikely that the journey itself will constitute a deprivation of liberty"

UNLESS

2.15 "it is necessary to do more than persuade or restrain (*all I can think of is to medicate*)…..or where the journey is exceptionally long *(not defined)*…..it may be necessary to seek an order from the Court of Protection

HOWEVER

How should managing authorities avoid unnecessary applications for standard authorisation?

2.16 …unnecessary applications…..may place undue stress upon the person…..and families or carers"

So, managing authorities should not make an application if they are not sure a deprivation is occurring. However, given the uncertainty about where a restriction becomes a deprivation this places a great burden on staff who may be poorly trained in the area deciding when the threshold is crossed. It may lead to unnecessary applications just so that people's "backs are covered".

Caselaw:

The Code then offers six legal judgements – three where a deprivation did not occur and three where one did – to clarify how the courts see the issue. In my opinion the three where

a deprivation is thought to occur are clear and unambiguous as are the three where a restriction occurred. It is the "grey" area where restriction becomes deprivation that we need help with. For example, what would constitute an exceptionally long trip to hospital (see paragraph 2.15) 1 hour? 2 hours? Is it distance or time? In the middle of the night a 50 mile journey could taken under an hour. At a busy time in a large city a 10 mile trip could take well over an hour. My own suspicion is that it is the amount of time that is the issue. None of the six cases noted include conveyance as an issue.

Cases..(which)..did not involve a deprivation of liberty.

2.18. "LLBCvTG (judgement of High Court of 14th November 2007).

TG was a 78 year old man with dementia and cognitive impairment. After a period in hospital the local authority obtained a court order to place him in a care home over the objections of his daughter and granddaughter who wanted him to live with them. Neither of these relatives were told of the court hearing. This order was eventually changed and he did go to live with his relatives. They claimed that the time he had spent in the care home amounted to a deprivation of liberty.

The Judge considered there had not been because

- " the care home was (one) where only ordinary restrictions …..applied
- the family were able to visit…..on a largely unrestricted basis and…..take him out
- TG was compliant and expressed himself as happy in the care home…..(for)…..over three years…..(he)…..was objectively content..
- there was no occasion where TG was objectively deprived of his liberty"

This is described as a borderline case. The only contentious issue, it seems to me, were his family's objections and the initial lack of openness / consultation (not being notified of the court hearing). Otherwise it seems that none of the triggers for a deprivation occurred. The lack of consultation and agreement was not enough to make this a restriction.

With regard to Jones' comments on what constitutes a DoL it would seem that, as the family objected, Jones would see this as a deprivation of liberty (points 2 and 5 on his first list quoted above).

2.19 "Nielsen V Denmark (ECtHR;(1988) EHRR 175)
The mother of a 12 year old boy arranged for his admission to the state hospital's psychiatric ward…..he had a nervous disorder and required treatment in the form of regular talks and environmental therapy …..duration was 5½ months.

The restrictions…..were not much different from …..(those)…..that might be imposed…..in an ordinary hospital. The door of the ward was locked to prevent children exposing themselves to danger or…..disturbing other patients (NOTE: it seems to be O.K. to lock a door to prevent people harming themselves or others, being at risk from those who might come into a unit BUT if the intent is simply to restrict movement then this does not seem O.K. – it seems hard, in practice, to think of units that are locked unless it is to protect people)….(He) was free to leave the ward with permission and go out if accompanied by a member of staff. He was able to visit his family and friends….

The Court held…..he was not detained as a person of unsound mind *(but he was on a psychiatric ward for a nervous disorder)*…..and the restrictions were no more than the normal requirements for the care of a child 12 years of age receiving treatment in hospital.

As the Act does not apply to 12 year olds I am not sure how much help this case is. It seems to reinforce the guidance that if people are allowed out of a locked unit with staff or family/carers (see scenario in Ch4 after 4.68) then that is not a deprivation unless it is for a "significant" (2.5) period. Clearly 5½ months is not seen as significant. Would 6 months be significant? When does a restriction become cumulative and frequent enough to be a deprivation.

2.20 "HM v Switzerland (ECtHR;(2002) 38 EHRR 314)
An 84 year old was placed indefinitely in a nursing home by the…..authorities…..after she and her son had refused to co-operate with…..(being cared for at home)…..and her living conditions had…..deteriorated (*the risk of harm issue*).

The woman was not…..(on a)…..secure ward…..(and)…..was free to move within the home and to have social contacts with the outside world…..initially…..(she)…..agreed to stay there…..(but)…..subsequently applied to the Courts saying that she had been deprived of her liberty.

(However as) the authorities had ordered the …..placement…..in her own interests in to provide…..necessary medical care and satisfactory living conditions…..the Court conclude(d)…..(this)…did not amount to a deprivation of liberty"

The patient did eventually object. The description in the Code of Practice does not make it clear whether she was allowed out to sustain social contacts or if people were allowed in with only reasonable restrictions to see her. It would also seem likely her son objected. Jones might well view this as a deprivation of liberty.

Cases where the Courts have found that the steps taken involve a deprivation of liberty.

2.21. DE and JE v Surrey County Council (SCC) (High Court judgement of 29th December 2006)

DE was a 76 year old man who, following a major stroke, had become blind and had significant short-term memory impairment. He also had dementia and lacked capacity to decide where he should live, but was still often able to express his wishes with clarity and force.

He was living with JE (his wife) but in August 2003 when she felt she could not care for him she "placed him on a chair in front of the house and called the police (and) the local authority placed him in (care)." "Within the care homes , DE had a substantial degree of freedom and lots of contact with the outside world…..(and was)…..never subject to…..restraint."

DE repeatedly expressed his wish to leave and JE wanted him to live with her. When considering whether there was a deprivation of liberty Justice Munby differentiated between leaving the home "for the purpose of some trip or outing…(and)….. leaving in the sense of removing himself permanently in order to live where and with whom he chooses". He concluded that as "DE will be permitted to leave the institution….only….when….[the local authority] considers it appropriate….(then the local authority)….is continuing to deprive DE of his liberty."

Clearly one of the things that differs between this and LLBC v TG is that TG seemed happy to stay where as DE was not. It is not clear from the summary whether JE was ever stopped from taking him out but another difference between the two cases is that DE had a "very substantial degree of freedom" whereas TG's family "were able to visit TG on a largely unrestricted basis and were entitled to take him out from the home for outings". This does suggest there were more restrictions on DE. Also, TG did leave the care home – although he was there for over three years – and the case appears to have been heard after he left. Had he not been allowed to leave might what was described as "a borderline" case actually have eventually amounted to deprivation?

2.22 The Bournewood Case i.e. HL V United Kingdom (ECtHR;(2004) 40 EHRR 761)
The Court said

"the key factor in the present case [is] that the health care professionals…..exercised complete and effective control over his care and movements from the moment he presented acute behavioural problems on July 22nd 1997 to the date when he was compulsorily detained on October 29th 1997"

If this case occurred after April 2009 would we use the MHA or MCA. They eventually used the MHA and did not apply for a Court Order. Is it of any help to us?

HL did not resist admission or try to leave. The summary does not say whether he verbally objected (like D.E. did).

His carers objected (like TG's) but, though the summary in the summary in the Code of Practice does not state, it I believe that contact with them was restricted (unlike TG's).

2.23 Storck V Germany (ECtHR; (2005) 43 EHRR 96)
It seems to me there is not much chance of this case being considered borderline.

"A young woman was placed by her father in a psychiatric institution…(on 3 occasions)…(Note: the Code does not describe her problems – might Mental Health legislation have been more appropriate?). She was kept in a locked ward under the continuous…control of the clinic personnel and…..not free to leave…..during her….stay of 20 months. When she attempted to flee, she was shackled. When she succeeded….she was brought back by the police. She was unable to maintain regular contact with the outside world….There was dispute about whether she consented to her confinement"

The Court noted;

"Under these circumstances, the Court is unable to discern any factual basis for the assumption – presuming she had the capacity to consent – that she agreed to her continued stay in the clinic".

She was felt to have been deprived of her liberty. No note is made of what actually happened to the young woman. Was she detained under some legal framework? Presumably she went to Court in the hope of being discharged. If she was not, would there be any comfort in knowing there had been some independent review? Perhaps she received compensation – though as the admissions were in the mid 1970's and the European Court heard the case in 2005 one hopes her situation had drastically improved.

The rest of the Code discusses the administrative details and are of less interest to potential BIAs in the key question i.e. deciding if a DoL is occurring. There are a number of practical issues BIAs should be aware of

(1) A BIA cannot assess someone if they are "involved in the care or treatment of the person they are assessing nor in the decisions about their care" (which is different to AMHP's who can see people they are working with. Indeed it might well be that much of the work that a social worker or other staff member does will be duplicated by the BIA. The assumption that there might be a conflict of interests between social workers and service users is sadly, in my view, one which seems to run through many recent initiatives which impact on social workers eg direct payments).

(4.13)

(2) Equivalent assessments; this is one that has been carried out in the last 12 months not necessarily for the purpose of DoL authorisation providing it

- meets all the requirements of a DoL assessment
- of which the supervisory body is satisfied it is still accurate and has a written copy.

e.g. a recent MHA assessment could be an equivalent for the Mental Health assessment

(4.4 – 4.9)

(3) There must be a minimum of 2 assessors and the mental health assessor and BIA **must** be different people

(4.13 and 4.39)

(4) The code seems to suggest that potential assessors should have "experience of working with the service user group from which the person being assessed comes (for example, older people, people with learning disabilities, people with autism, or people with brain injury)

(4.14)

In practice this may be difficult to achieve within a local authority area. There may only be one or two specialists in some fields of practice who may well be already involved in a case which then needs assessment for DoL. Of course, this does depend on how experience is defined.

(5) "…..the bests interests assessment…..(should not be)…..started until there is a reasonable expectation that the other five qualifying requirements will be met."

(4.20)

(6) "The first task of a best interests assessor is to establish whether deprivation of liberty is occurring, or is likely to occur, since there is no point in the assessment process proceeding further if deprivation of liberty is not an issue."

(4.62)

(7) The BIA "state(s) what the maximum authorisation period should be …this must not exceed 12 months"

(4.71)

(8) …the best interests assessor must, as part of the assessment process, identify if there is anyone they would recommend to become the relevant person's representative. The best interests assessor should discuss the representative role with the people interviewed as part of the assessment."

(7.10)

Timescales;

4.9 …all assessments required for a standard authorisation must be completed within 21 calendar days from the date on which the supervisory body receives a request…"

4.10 …if an urgent authorisation is already in force, the assessments must be completed before the urgent authorisation expires…"

4.11 Urgent authorisations may…exceed…seven days (for an initial period) …..exceptional(ly)…they may be extended…. for up to a further seven days."

Do the scenarios in the Code of Practice offer any further guidance on how to decide whether a restriction or a deprivation is occurring?

In Chapter 4 (after 4.68) the scenario concerns a Mr Simpson whose daughter agrees that he can be prevented from going out unless with either her or a staff escort. He is in a care home and consented to the admission. Whilst the scenario does not state whether he agrees with these restrictions it does state that the staff have no trouble getting him back to the home. The scenario suggests he will have a number of short trips out with restrictions on where he goes and what he is able to do. This would be seen as a restriction but will be reviewed in 2 months

Conclusion: So, does this offer any clarity? Jones' lists seem clear and do reflect the caselaw. Simply preventing a person leaving a care home or hospital is not something the courts regard as a deprivation. Where family / carers agree, where the person is allowed out (even if escorted only when escorts are available), where visitors have ready access, where the person does not resist or can be gently persuaded (even to the extent of gently forcing) to return to or stay even on a locked unit – all of these are factors we must consider.

If the restriction is frequent and cumulative then it may become a deprivation. Unfortunately we do not have clear definitions of these variables. One of the key cases quoted (TG) was not considered a deprivation though he was restricted for over three years despite the objections of his family.

Interesting times lie ahead. As the case law builds up the variables will, no doubt, become more clearly defined. Providing we act in the person's best interests to prevent harm, our actions are proportionate and we have consulted all who have a legitimate interest, acted in good faith and recorded what we have done then we should have nothing to fear.

References:

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