# The Mental Capacity Act 2005
# Deprivation of Liberty Safeguards – the early picture

## Introduction

1. The Mental Capacity Act Deprivation of Liberty Safeguards (MCA DOLS) were introduced, as part of the Mental Health Act 2007, by the Department of Health in April 2009. The MCA DOLS are new statutory safeguards.

2. The MCA DOLS were introduced to prevent deprivations of liberty without proper safeguards including independent consideration and authorisation. Deprivations of liberty in hospitals or care homes, other than under the Mental Health Act, should now follow the MCA DOLS process and all affected patients and residents should benefit from the new safeguards. The NHS and Social Care Information Centre published activity data for MCA DOLS, for the first time, in March 2010.
http://www.ic.nhs.uk/statistics-and-data-collections/mental-health/mental-health-act/quarterly-analysis-of-mental-capacity-act-2005-deprivation-of-liberty-safeguards-assessments-england-quarters-1-to-3-2009-10

## Number of people benefiting from DOLS safeguards

What do the numbers show?

3. Firstly, some five and a half thousand people have benefited from the new MCA DOLS safeguards, in the first nine months. This means some five and a half thousand people have had their deprivation of liberty independently assessed and considered by best interests assessors. The Department is expecting the figure, by the end of the first year, to be about seven thousand.

4. Secondly, the published data refers only to completed cases, so is a slight underestimate of the activity. However, activity levels are at about a third of the level estimated prior to the introduction of the new safeguards. Fewer people than thought are receiving care or treatment which involves them being deprived of their liberty, but there are probably a number of deprivations not recognised and not authorised.

5. Thirdly, approximately half of the assessments are resulting in authorisations rather than the quarter predicted.

6. There appears to be a better understanding of the complexities of the case law in relation to the circumstances that may constitute a deprivation of liberty than was anticipated at this, still, early stage in the implementation of the Safeguards.

7. Fourthly, there are significant variations in activity levels in different areas and, notwithstanding the success of the training and awareness raising, it is

likely that activity levels continue to be lower than could be reasonably expected in some areas. DH regional implementation leads continue to work closely with all areas to ensure the legislation is properly applied.

## Case law developments

8. There have been three significant case law judgments that managing authorities (hospitals and care homes) and supervisory bodies (primary care trusts and local authorities) and supervisory bodies (hospitals and care homes) and best interests and eligibility assessors should be aware of. The Department has produced guidance on these judgments http://www.dh.gov.uk/en/Healthcare/Mentalhealth/DH_111770

## Emerging practice issues

9. Five practice issues, in particular, have arisen in the Department's implementation team's ongoing work with organisations and individuals.

### i) The choice of the Relevant Person's Representative (RPR)

10. Paragraph 7.17 of the Deprivation of Liberty Safeguards supplement to the Mental Capacity Act 2005 Code of Practice states

*"It should not be assumed that the representative needs to be someone who supports the deprivation of liberty."*

11. The Department is aware of a number of cases where family members have not been selected to be the RPR where they have not been supportive of the deprivation of liberty. That alone is not grounds for not selecting them for the role. Best interests assessors need to assure themselves that the individuals in question are inappropriate for other reasons, which may include that they simply do not wish to take on the role.

12. Both the person "P" now deprived of his or her liberty and his or her RPR have an automatic non-means tested right of appeal to the Court of Protection. Where a family member is not selected to be the RPR and they wish to challenge the authorisation they can only apply to the Court, for a best interests determination and incur the costs of such an application.

13. Sometimes the MCA DOLS authorisation is the culmination of a lengthy dispute between the family and an NHS Trust or local authority about where the person should live. Paragraph 8.28 of the Mental Capacity Act 2005 Code of Practice states that a *"court decision might be appropriate*" where *"there is a major disagreement regarding a serious decision (for example, about where a person who lacks capacity to decide for themselves should live*)"

14. Such disputes, which can not be otherwise resolved, will require the "last resort" determination of the Court rather than being resolved via the Safeguards.

**ii) Where a DOL is not authorised**

15. In the first nine months there were125 recorded instances of cases where a person had been found to be deprived of their liberty but a best interests assessor had not recommended an authorisation as in their view it would not be in that individual's best interests, because a less restrictive option is or could be available.

16. Paragraphs 4.72 and 4.73 of the Deprivation of Liberty Safeguards supplement to the Mental Capacity Act 2005 Code of Practice state:

*The best interests assessor must provide a report that explains their conclusion and their reasons for it. If they do not support deprivation of liberty, then their report should aim to be as useful as possible to the commissioners and providers of care in deciding on future action (for example, recommending an alternative approach to treatment or care in which deprivation of liberty could be avoided). It may be helpful for the best interests assessor to discuss the possibility of any such alternatives with the providers of care* ***during the assessment process****.*

*If the best interests assessor does not support deprivation of liberty, it would be good practice for their report to be included in the relevant person's care plan or case notes, to ensure that any views about how deprivation of liberty can be avoided are made clear to the providers of care and all relevant staff on an ongoing basis.*

It is not known whether this occurred in each of the 125 recorded cases but the Code advises that it should have been done. A number of local authorities have "alerts" in their policies and procedures to ensure that action is taken swiftly to end what is otherwise now an unlawful deprivation of liberty as swiftly as possible. It is recommended that all managing authorities and supervisory bodies have a mechanism that permits the swiftest possible response to these circumstances.

**iii) Setting conditions and effective care planning**

17. There is evidence that the Code's guidance in relation to the setting of conditions is not being adhered to. Paragraphs 4.74.and 4.75 of the Deprivation of Liberty Safeguards supplement to the Mental Capacity Act 2005 Code of Practice state:

*The best interests assessor may recommend that conditions should be attached to the authorisation. For example, they may make recommendations around contact issues, issues relevant to the person's culture or other major issues related to the deprivation of liberty, which – if not dealt with – would mean that the deprivation of liberty would cease to be in the person's best interests. The best interests assessor may also recommend conditions in order to work towards avoiding deprivation of liberty in future. But it is not the best interests assessor's role to specify conditions that do not directly relate to the issue of deprivation of liberty*

*Conditions should not be a substitute for a properly constructed care plan. In recommending conditions, best interests assessors should aim to impose the minimum necessary constraints, so that they do not unnecessarily prevent or inhibit the staff of the hospital or care home from responding appropriately to*

*the person's needs, whether they remain the same or vary over time. It would be good practice for the best interests assessor to discuss any proposed conditions with the relevant personnel at the home or hospital before finalising the assessment, and to make clear in their report whether the rejection or variation of recommended conditions by the supervisory body would significantly affect the other conclusions they have reached.*

18. Best interests assessors need to recommend and supervisory bodies to set conditions that reflect the advice in the supplement to the Code and not, as has been reported to the Department, recommend and set conditions that otherwise could have been achieved by effective care plans.

**iv) The involvement of the Court of Protection in proposals of "no contact" with named individuals**

19. Safeguarding teams will be required, at times, to consider matters of contact between a person lacking capacity and somebody that they may be at risk of harm or abuse from. Paragraph 4.74 of the Deprivation of Liberty Safeguards supplement to the Mental Capacity Act 2005 Code of Practice recognises contact might be an issue in the setting of conditions,
"*The best interests assessor may recommend that conditions should be attached to the authorisation. For example, they may make recommendations around contact issues".*
This could include conditions that allow or encourage contact as well as conditions that limit or supervise contact.

20. There may be a short-term need to rely on the conditions of an authorisation to manage no contact in such cases but paragraph 8.28 of the Mental Capacity Act 2005 Code of Practice states "a court decision might be appropriate" where "someone suspects that a person who lacks capacity to make decisions to protect themselves is at risk of harm or abuse from a named individual (the court could stop that individual contacting the person who lacks capacity)."

21. This suggests that the Court should be the arbiter for matters of no contact and that an authorisation under MCA DOLS, other than as a very short-term measure, should not be relied upon to manage no contact cases. Local authorities and PCTs seeking authority to prevent contact are advised by the Code that "a court decision might be appropriate" in such circumstances,

22. Case law judgements, to date, indicate that preventing contact with somebody who presents a risk of harm or abuse to a person lacking capacity does not on its own amount to a deprivation of their liberty. An authorisation should not therefore be recommended nor granted on these grounds alone.

v) **Where an authorisation fails to resolve a dispute**

23. Where an authorisation and/or any of its conditions fails to stop the continuing or new opposition of a family member, then a dispute cannot be considered to have been resolved.

24. Cases which are subject to dispute and cannot be otherwise resolved will require the last resort determination of the Court of Protection, and should not be viewed as having been resolved via the MCA DOLS process.