Deprivation of liberty

Ruth Cairns

Abstract
The Mental Capacity Act Deprivation of Liberty Safeguards have been introduced to provide a framework for people who are, or may become, deprived of their liberty. Here, I describe the background to the legislation and the assessment process that leads to authorisation of deprivation of liberty. I also outline the review and appeal processes and consider some of the challenges that may be associated with implementing the new legislation.

Keywords Bournewood case; deprivation of liberty; deprivation of liberty safeguards; European Convention of Human Rights; mental capacity

Background
The Mental Capacity Act (MCA) Deprivation of Liberty Safeguards (DoLS) have arisen in response to the European Court of Human Rights’ (ECtHR) judgment in the case of HL vs UK.1,2 HL was a man with autism and learning disability who lacked capacity to consent to his admission to Bournewood Hospital following an episode of self-harm. He had not objected to or resisted this, and was admitted as an informal patient. He was, however, required to remain in hospital and would have been prevented from leaving if he had tried to do so. The paid carers with whom he lived requested his release back into their care but this was refused by the hospital and the carers were not allowed to visit him.

The case was taken to the House of Lords in 1998.3 It was found by a majority judgment that HL was not detained or deprived of his liberty and a unanimous judgment was made that admission and treatment under the common law doctrine of necessity had been lawful. However, when the case reached the ECtHR, it was ruled that HL had been deprived of his liberty during his admission to Bournewood Hospital. Furthermore, common law – widely used to detain in cases of incapacity – was not compliant with Article 5 of the European Convention on Human Rights (ECHR): specifically, it contravened a person’s right to be detained only by “a procedure prescribed by law” and also to speedy access to a court to see if the detention was lawful.2,4

What is a deprivation of liberty?
The ECtHR has drawn a distinction between the unlawful (unless authorised) deprivation of liberty and lawful restriction on the movement of a person. This distinction depends on the particular circumstances of a case: “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

The DoL Code of Practice advises that “there is no simple definition of deprivation of liberty.... it is ultimately a legal question, and only the courts can determine the law”.1 However, the case of HL provided guidance on identifying DoLs, and a number of other European and domestic cases have also considered the distinction. The Code does therefore offer a list of seven factors derived from these cases that should be considered when determining if a DoL is likely to occur (see box 1).1

Decision makers are advised to consider all the circumstances of each individual case, including the measures being taken, the duration of any restraints or restrictions, and their effect on the individual. Unfortunately, the Code advises that “there is unlikely to be any simple definition that can be applied in every case, and it is probable that no single factor will in itself, determine whether the overall set of steps being taken in relation to the relevant person amount to a deprivation of liberty”.1 The cumulative effect of all the restrictions imposed also needs to be considered, even if individual restrictions do not amount to a DoL.

Applying for authorisation of deprivation of liberty
A hospital or care home (referred to as the managing authority) has responsibility for applying to their primary care trust or local

Factors contributing to a deprivation of liberty1

- Use of restraint, including sedation, to admit a person to an institution when that person is resisting admission
- Complete and effective control exercised by staff over the care and movement of a person for a significant period
- Control exercised by staff over assessments, treatments, contacts and residence
- Decision taken by the institution that the person will not be released into the care of others, or permitted to live elsewhere, unless staff in the institution consider it appropriate
- Refusal to carers’ request for a person to be discharged into their care
- Person unable to maintain social contacts because of restrictions placed on their access to other people
- Person loses autonomy because they are under continuous supervision and control

Box 1

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1. This case, known as the Bournewood case, has changed the legal landscape. The Mental Health Act (MHA) 2007 was used as a vehicle to amend the MCA 2005 and introduce the DoLS, which came into force in England and Wales on 1st April 2009.5,6 The safeguards apply to people aged 18 or over with a mental disorder who lack capacity to consent to admission for care or treatment in hospital or a care home, when circumstances amounting to a deprivation of liberty (DoL) are required to provide this. The MCA safeguards only apply in situations whereby detention under the MHA is not appropriate for the person at that time. Common law can no longer be used, and detention that is not under the MHA or DoLS is unlawful.

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Ruth Cairns MBBS BSc MRCPsych is a Chadburn Lecturer in Liaison Psychiatry at the Institute of Psychiatry and an Honorary Specialist Registrar in General Adult and Old Age Psychiatry at the Maudsley Hospital, London, UK. Her research interests include mental capacity and deprivation of liberty. Conflict of interests: none declared.
social services (called the supervisory body) respectively for authorisation of DoL. A standard authorisation (SA) permits lawful DoL and, wherever possible, should be applied for in advance once the care plan has shown that less restrictive measures cannot meet the person’s needs. Managing authorities can also issue urgent authorisations. At the time of issue, the managing authority must also apply to the supervisory body for a SA to be issued within the period of the urgent authorisation (maximum seven days).

Assessment process

The supervisory body is legally responsible for commissioning six assessments to establish whether or not the qualifying requirements for the safeguards are met. This must be completed within 21 calendar days, or before the urgent authorisation expires. If any of the assessments say ‘no’, the authorisation cannot go ahead.

The first three assessments involve establishing that the relevant person is aged 18 or over; has a mental disorder; and lacks capacity to consent to admission to the hospital or care home to receive care or treatment. An “eligibility assessment” then considers the relevant person’s status, or potential status, under the MHA.

A number of factors make a person ineligible for a DoLS authorisation, including detention as an inpatient under the MHA 1983 and an obligation under the MHA to live somewhere else: for example, while on leave from detention under the MHA or when subject to guardianship, conditional discharge or supervised community treatment. When the authorisation involves DoL for treatment of mental disorder, a relevant person’s objection to admission or treatment makes them ineligible for DoLS if they also meet criteria for detention under Section 2 or Section 3 MHA. Objection to detention does not, however, render a person ineligible for DoLS when the DoL is in a residential care or nursing home. This means that the legal regime used will change according to the place of detention. For example, a person with dementia who objects to detention in a psychiatric hospital and then moves into residential care, where DoL remains necessary, will also move from being detained under the MHA to being detained under MCA DoLS at this time.

The “best interests” assessor establishes whether DoL is, or is going to, occur and, if so, the assessment proceeds to consider whether the DoL is necessary, is in the person’s best interests, and is a proportionate response to the likelihood of the relevant person suffering harm and the seriousness of that harm. The “no refusals assessment” ensures that an authorisation would not conflict with a valid advance decision of the relevant person, or a valid decision of a donee or deputy, to refuse treatment.

Assessors

There must be a minimum of two assessors for the six assessments, and the mental-health and best-interests assessors must be different people. Equivalent assessments may be used if they have been completed in the last 12 months and are still valid. The mental-health assessor must be an experienced doctor who has completed standard DoLS training and the best-interests assessment must be undertaken by a social worker, nurse, occupational therapist or psychologist who has completed the standard training. However, for DoLS to be authorised, the eligibility assessment must be performed by either a Section-12 approved doctor or a best-interests assessor who is also an approved mental-health professional (AMHP).

The best-interests assessor seeks the views of a range of people connected to the relevant person and also appoints the relevant person’s representative, whose role it is to represent and support the relevant person in matters relating to the authorisation. This includes help with using the review process and accessing the Court of Protection. The person and their representative also have a statutory right to an Independent Mental Capacity Advocate (IMCA). If the best-interests assessment supports an authorisation, the assessor must state the maximum authorisation period and can also attach conditions to the authorisation. A SA can last for up to 12 months but DoL should only last for the minimum period necessary.

Reviews and the court of protection

A SA can be reviewed by the supervisory body at any time, either at the request of the managing authority, the relevant person or their representative. The grounds for review include changes in the relevant person’s situation, making it necessary to amend conditions attached to the SA, and concerns that the statutory requirements for a SA are no longer being met. For example, if a relevant person is in hospital for the purpose of receiving mental-health treatment and has started to object to this, the eligibility requirement for authorisation of DoL will no longer be met.

The Court of Protection was established by the MCA 2005 to review the lawfulness of DoL authorisations and to comply with Article 5 of ECHR. Applications can be made either before or after an authorisation is given. The relevant person, their representative, an appointed court deputy and a donee of a lasting power of attorney all have automatic right of access to the Court. Concerns should be resolved informally or through local supervisory body or managing authority complaints procedures wherever possible.

Challenges to implementation

The DoLS have been criticised for their complexity. The failure of the MCA to provide a clear definition of DoL means that, in effect, clinical teams are provided with a range of factors to consider but without clear indication of the priority to be given to each. Current guidance is based on existing case law and is open to different interpretation. The Joint Committee on Human Rights has criticised the government’s guidance for not reflecting Munby J’s view, in DE and JE vs Surrey County Council, that they key factor in determining whether there is DoL is whether or not the person is free to leave.

There are also concerns about the unclear interface between DoLS and the MHA. There is considerable overlap between the two pieces of legislation and in certain situations it will not be clear which should be used. Contributing to this problem is the emphasis placed on “objection” as a deciding factor between the two detention regimes. Little clear guidance is available for clinicians to aid the judgment about when a person is ‘objecting’. This has led to the criticism that the judgment becomes overwhelmingly clinical rather than legal, and may result in arbitrary
decisions being made about whether the MHA or MCA DOLS should be used to detain patients with the same condition.12

REFERENCES
2 HL v UK (2005) 40 EHRR 437.
3 R v Bournewood Community and Mental Health Trust ex parte L (1998) 3 A11 ER 289 HL.
9 Richardson G. Mental Capacity at the Margin: The Interface之间 Two Acts. Under review.