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Deprivation of Liberty Safeguards: putting them into practice



This resource describes good practice in the management and implementation of the Deprivation of Liberty Safeguards.

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Introduction

This resource describes good practice in the management and implementation of the Deprivation of Liberty Safeguards (DoLS; the Safeguards). It includes the roles of clinical commissioning groups (CCGs) and wider local authority governance. The resource is structured with freestanding sections on hospitals, care homes, supervisory bodies, assessors and authorisers, hence there is some inevitable repetition between them.

The resource is not intended to be a complete and authoritative statement of the law, and should not be relied on as such. Examples of good or innovative practice are used to show how the Safeguards can work effectively to protect the human rights of the most vulnerable adults in society, but it is not suggested that the practice described is the only way to achieve this.

Since the introduction of DoLS, there is some encouraging evidence of human rights-based practice becoming central to the relationship between health and social care professionals, those who might lack capacity for some essential decisions, and their families or friends.

Human rights-based practice is supported and led by both the Court of Protection and the European Court of Human Rights (ECtHR), with increasing numbers of cases concerning deprivation or restriction of liberty, the boundary between the two, and the essential questions of how to balance the wishes and the welfare of vulnerable people.

This resource has been reviewed and updated following the Supreme Court judgment in the P v Cheshire West and Chester Council and another and the P and Q v Surrey County Council cases on 19 March 2014.⁷⁰

It should be remembered that the Safeguards referred to in this resource only relate to hospitals and care/nursing homes. Cases of Deprivation of Liberty in other settings need to be referred direct to the Court of Protection for determination.

The importance of the Mental Capacity Act

The Mental Capacity Act (MCA) 2005, which consolidates human rights law for people who might lack capacity to make their own decisions, is the foundation for DoLS. It is designed to promote the empowerment of individuals and the protection of their rights. The MCA is built on five statutory principles that guide and inform all decision-making in relation to the estimated 2 million people who may lack capacity for decision-making in some aspect of their lives. The MCA is the essential and required framework for health and social care commissioning and practice.

A deprivation of liberty can only be authorised under the MCA when there is evidence that a person lacks capacity for specific decision-making about whether they should be accommodated in a hospital or care home and when the proposed care arrangements that deprive that person of their liberty are in their best interests.

All providers and commissioners of health and social care must therefore have a good understanding of the MCA. This will ensure that appropriate assessments of capacity are carried out, including all possible attempts to empower people to make relevant

decisions for themselves. It will also ensure that decisions made for those who lack the required mental capacity are in their best interests.

Any situation calling for a request for authorisation under DoLS must first meet the general requirements of the MCA. This means that care planning within hospitals and care homes, as in other settings, must be compliant with the Act. Demographic changes, such as an ageing population and longer life spans for people with learning disabilities, mean that an increasing proportion of people who receive health and social care may lack capacity to consent to or refuse some interventions, or indeed are at risk of being presumed to lack capacity due to stereotyping based on their age or diagnosis.

The Safeguards apply in England and Wales to situations when care or treatment is provided to a person who lacks the mental capacity to consent to arrangements proposed for that care or treatment in a hospital or care home, and the arrangements amount to a deprivation of liberty.

The Safeguards provide a legal framework to prevent breaches of Article 5 of the European Convention of Human Rights¹ (ECHR), which states:

1 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 ...

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 by a court and his release ordered if the detention is not lawful.

Example from practice

Mrs F (88) had a long history of dementia. She lived alone and very independently in a spotless bungalow, maintaining strict routines, but was neglectful of herself (often forgetting to eat and drink properly). One day, Mrs F left an electric heater on, covered by clothing, then tried to put the resulting flames out with water and by cutting the cable to the plug without turning the electricity off. The fire was serious, and she was admitted to hospital. She was very confused, and left the hospital twice, in her nightclothes, trying to go home. On both occasions the police found her in a distressed state, and returned her to the hospital.

The hospital, as the managing authority, gave itself an urgent authorisation in order to make it legal to deprive Mrs F of her liberty, in her best interests. At the same time, the hospital applied for a standard authorisation under DoLS from the supervisory body.

The best interests assessor agreed that Mrs F was being deprived of her liberty, and that this was in her best interests. He suggested a short period of standard authorisation, with conditions around care planning, and a best interests meeting to ensure that the least restrictive option for Mrs F's care was identified. This was authorised by the local authority authorising signatory. Due to her lack of family or close friends, an independent mental capacity advocate (IMCA) was part of the assessment process.

When she had recovered from the effects of the fire, Mrs F was admitted to short-term residential care, while her house was being repaired. The care home, the new managing authority, applied in advance of her admission for a standard authorisation, which was approved (authorisations are place-specific, so the hospital authorisation did not 'travel' with Mrs F).

Mrs F's social worker and the best interests assessor both felt she still did not have the mental capacity to make her own decisions about where she should live, but they acknowledged her strong desire to go home.

The repair of her home following the fire took several weeks, during which time a series of best interests meetings identified a plan for her return. Mrs F agreed that it would help her to have a live-in carer, and visited home several times with her social worker and IMCA to prepare for her return home. She returned and all went well for a few days, but then there was an aggressive incident towards her carer. Mrs F asked to go back to 'the lovely care home to my friends'. She returned to the care home where she remains, now settled and calling it her home.

Use of DoLS in hospitals

Introduction

The Safeguards have been in operation since 1 April 2009 and hospitals will be familiar with them, the Regulations supporting the Safeguards, the Code of Practice (DoLS code), guidance and forms.² Many will have extensive experience of making applications, the assessment process and putting into practice an authorisation.

This section builds on what has been achieved to date and gives practice examples that promote compliance with the Regulations and Code³ and the continuing protection of the rights of vulnerable people who are unable to consent to their care and treatment.

The guidance applies to all hospitals (including hospices), whether in the public, private or charity sector, irrespective of type (i.e. acute, community, mental health, etc.).

There are estimated to be some 2 million people in England and Wales at any one time who are unable to consent, in whole or part, to their care and treatment.⁴ In 2015–16, 195,840 deprivation of liberty applications were made, and a little over 105,000 assessments were completed. In 76,530 (73 per cent) of these, the deprivation was authorised. Of the applications, 35,635 came from acute and mental health hospitals in the public and independent sectors. These figures compare with the roughly 11,000 applications made annually in hospitals and care homes combined prior to the 2014 Supreme Court judgement.⁵

For many practitioners the need to use the Safeguards will be infrequent. It is, therefore, important that hospitals do not neglect the Safeguards as a result of a lack of familiarity and find themselves unlawfully depriving a person of their liberty or, conversely, letting a person come to harm when use of the Safeguards might have protected them.

Application of the Safeguards is variable across England. The reasons for this are unclear but it may suggest that the Safeguards are not being fully embedded in organisations or that training is inconsistent. A report on the use of the Safeguards in hospital settings highlights the range of training and awareness, as well as wide variations in practice concerning who can sign an urgent authorisation to deprive a patient of their liberty.⁶

As a general guide, any institution, ward or professional caring for or providing treatment for people with dementia, a mental illness, a learning disability or an acquired brain injury should be familiar with the Safeguards. This is irrespective of the person using the service's age once they reach adulthood (18 years), the funding arrangements for their care or the speciality caring for them – for example, a person with a learning disability may be occupying a surgical bed for removal of tonsils or a person with dementia may be receiving treatment in a medical ward.

Organisations will know that it is unlawful to deprive a person of their liberty in a setting other than a hospital or care/nursing home and any such cases should be referred to the Court of Protection for determination. Examples would be a deprivation of liberty in supported living accommodation or in a person's own home.

The Care Quality Commission (CQC) provides guidance on both the MCA and DoLS.⁷ It is important that providers use it to judge whether they are meeting their duties and responsibilities under the Act.

The Bournemouth judgement

The Safeguards were introduced to provide a legal framework around deprivation of liberty in a care and treatment setting, and prevent breaches of the ECHR such as that identified by the judgement of the ECtHR in the case of *HL v. the United Kingdom*⁸ (commonly referred to as the 'Bournemouth judgement', from the name of the hospital involved). The case concerned an autistic man (HL) with a learning disability, who lacked the capacity to decide whether he should be admitted to hospital for specific treatment. He was admitted on an informal basis under the common law in his best interests, but the decision was challenged by HL's carers, who asked to take him home and were refused.

In its judgement in 2002 the Court held that this admission constituted a deprivation of HL's liberty in that:

- the deprivation had not been in accordance with 'a procedure prescribed by law' and was therefore in breach of Article 5(1) of the Convention
- there had been a contravention of Article 5(4) of the Convention because HL had no means of applying quickly to a court to see if the deprivation was lawful.

The MCA 2005 was amended to provide safeguards for people who lack capacity to consent to treatment or care in either a hospital or a care/nursing home that, in their own best interests, can only be provided in circumstances that amount to a deprivation of liberty.⁹ The later section entitled 'What is deprivation of liberty?' provides guidance on how to identify when a deprivation of liberty may be occurring.

Winterbourne View and Mid Staffordshire Hospital

The circumstances of HL's care are not isolated. Reports into care, including at Winterbourne View and Mid Staffordshire Hospital, have highlighted issues where basic human rights have not been recognised and people have been neglected and abused as a result.¹⁰

The Safeguards do not authorise abusive practice and applications should not be seen as a way to legitimatise this. On the contrary, an application is a demonstration that staff understand people's rights and are acting to promote and protect their rights and best interests.

- The Safeguards are just part of the framework within which hospitals should be working to ensure they respect people's human rights and dignity. This framework is set down in law and includes:
- Human Rights Act (HRA) 1998
- Mental Capacity Act (MCA) 2005
- Disability Discrimination Acts (DDA) 1995 and 2005

- Equality Act (EA) 2010

DoLS and the experience of people who use services

Applying the Safeguards should not be seen as something separate from providing core health services. It is integral to the measures a hospital must take to protect and promote the rights of people who use services. Auditing the use of the Safeguards should, therefore, be part of an organisation's quality improvement programme covering policy, audit, staff training, patient information, relative involvement and reporting on numbers of applications and outcomes. How the Safeguards are managed and implemented should form part of a hospital's governance programme and the section (below) entitled 'Applying DoLS in practice' sets out what the programme in respect of the Safeguards might look like.

DoLS and the MCA 2005

The Safeguards are part of the MCA and cannot be effectively applied unless staff are familiar with the Act and have received appropriate training. The five statutory principles set down in Part 1 paragraph 1 of the Act equally apply to a patient for whom the Safeguards might be relevant:

- **a presumption of capacity:** every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise in respect of each specific decision
- **individuals must be supported to make their own decisions:** a person must be given all practicable help before anyone treats them as not being able to make their own decisions
- **unwise decisions:** just because an individual makes an unwise decision, they should not be treated as lacking capacity to make that decision
- **best interests:** an act done or decision made under the Act for or on behalf of a person who lacks capacity must be done in that person's best interests
- **less restrictive option:** a person doing anything for or on behalf of a person who lacks capacity should consider options that are less restrictive of their basic rights and freedoms while meeting the identified need.

The less restrictive option is particularly important in relation to the Safeguards. For example, an incapacitated person on a medical ward receiving treatment for diabetes is prone to wander and might get lost and come to harm. They are persistently trying to leave the ward to the extent an authorisation under the Safeguards might be required. Staff need to consider the steps necessary to protect the person from harm while at the same time ensuring those actions are the least restrictive possible of the person's basic rights and freedoms.

Applying DoLS in practice

As part of a hospital's quality improvement and governance arrangements there should be a framework in place that promotes the effective use of the Safeguards. (For the

purposes of the legislation, a hospital considering an application for a deprivation of liberty authorisation is known as a 'managing authority'.)

The framework used by all hospitals should include the following.

- **Staff training** on the Safeguards (as part of wider MCA training) so that staff know how to assess for deprivation of liberty and recognise when care goes beyond restriction of movement and restraint which is lawful under the Act and towards deprivation of liberty. This training should feature in induction, training and refresher programmes and records of completed training should be kept.
- An **organisational policy and procedure** with particular reference to sections relating to training, levels of responsibility, access to and completion of requests for standard authorisations (form 4), urgent authorisations (form 1) and situations in which they can be used.
- A schedule of senior staff authorised to sign off applications before they are submitted to the supervisory body.
- **Guidance on care planning** which includes the Safeguards and explains how they support an effective care plan and are not a substitute for good care planning. Consideration should always be given to finding wherever possible alternatives to depriving a person of liberty: evidence of such consideration is explicitly required to create an urgent authorisation and in the application process for a standard authorisation (see DoLS form 1).
- **Arrangements for training on restriction and restraint** and associated record-keeping, with particular reference to care that moves from restriction and restraint towards deprivation of liberty. Staff should be sensitive to the relationship between restriction, restraint and deprivation of liberty and aware that whenever restriction is being used or considered it could in fact be a deprivation of liberty. If there is doubt an assessment should be sought, as explained in this resource.
- **Procedures for scrutinising care plans** by the hospital, to ensure that the least restrictive option is chosen which meets the need to prevent any likely harm to the person using the service, and is proportionate to that harm.
- A policy on how the hospital involves the person using the service (known within the DoLS process as the 'relevant person'), and their family and carers in decision-making.
- A programme of **audit work** covering application of the Safeguards.
- A **named person** with responsibility for responding to CQC reports, relating to the hospital's compliance with the MCA and DoLS.
- **Arrangements for urgently reviewing care plans** in circumstances where a best interests assessor finds a relevant person subject to a deprivation of liberty regime which is found not to be in that person's best interests.

- A named person with the duty to report DoLS applications and outcomes to the CQC.
- A named person with the duty to report DoLS applications, trends and problems to the hospital board overseeing quality.
- A policy on where responsibility lies for the preparation and review of care plans.
- **A policy on working in partnership with supervisory bodies** and supporting assessors with access to records, and enabling them to interview the relevant person and their family/carers.
- **Location of application forms** (electronic versions of the forms can be stored at the hospital, and details on how to obtain them are available from any supervisory body).
- Patient and relative/carer information leaflets about the Safeguards and the local procedure
- **A policy relating to reviewing authorisations** and what actions to take when an authorisation ends.
- A policy on working with and supporting the relevant person's representative.
- Arrangements for ensuring any conditions attached to an authorisation are complied with.
- Arrangements for access to legal advice, including when to seek advice from the Court of Protection.

Depriving a person of their liberty is not a decision that should be taken lightly even if it is in that person's best interests. Hospitals should, therefore, have a procedure for agreeing who is authorised to sign applications and urgent authorisations, and this list should be formally approved. This is to ensure that there is awareness at senior level when restraint is being practised: it is not intended to discourage the application of the Safeguards.

The person authorised to sign off an application should be aware of, and involved, each time an application is being prepared. The list should be formally reviewed on a regular basis and staff should be trained to undertake their designated roles.

A survey of hospitals showed that the number of staff who sign applications, and urgent authorisations to deprive people of their liberty for up to seven days ranges from one or two to over 100 per hospital.¹¹ It seems highly unlikely that any hospital management can keep effective governance over an excessively large number of authorisers, nor that large numbers of authorisers can create systems for auditing the use of restriction and restraint in the hospital with a view to minimising their occurrence.

DoLS and the care plan

An authorisation to deprive a person using the service of their liberty is part of that person's care plan and not a substitute for it.

The care plan should be put together in accordance with the framework set down in the MCA 2005 and follow what the Act and subsequent case law says about capacity and best interests assessments. This includes the statutory duty to commission an IMCA in certain situations if the person has no family or friends to be consulted. The duty in the Act to consult with persons with an interest in the welfare of the relevant person equally applies to the Safeguards. It should of course also be built on the wishes and feelings of the relevant person, and should give reasons if and why these wishes and feelings are not being allowed, and what less restrictive options for the person's care have been considered.

Working with the local authority as the supervisory body

On 1 April 2013 the supervisory body function previously undertaken by primary care trusts transferred to local authorities. Provision was made for this in the Health and Social Care Act (HSCA) 2012. This in no way alters the responsibilities of NHS and private sector hospitals beyond forwarding applications for authorisation to a different organisation. The regulations and guidance in respect of hospitals remain in place and the duty to seek authorisation when a deprivation of liberty is being sought, in the best interests of a person using the service unable to consent, remains.

Hospitals will wish to work with their local authority to secure clear lines of communication and co-operation. Each hospital's local authority will have a DoLS office. For hospitals this means:

- keeping up to date and accurate contact information on their local authority DoLS office
- having a policy and procedure agreed with the local authority that allows assessors to have access to the person using the service in question, their family and carers, and relevant records (DoLS assessors have a statutory right to access relevant patient notes)
- staff knowing their organisation's procedure for applying for a deprivation of liberty
- hospitals and local authorities agreeing a secure method of transferring identifiable information (e.g. encryption, secure network, safe haven, fax).

Case law

The case law relating to the Safeguards is evolving all the time and interpretation can be challenging. It is important that hospitals have access to reliable sources of information and guidance on case law developments so they can be applied to local practice where necessary. Hospitals will wish to ensure that their directly employed or contracted legal advisers are up to date on Court of Protection judgements and that processes exist for these legal advisers to feed the messages and the learning from case law into practice regularly.

It is essential hospitals are aware of the Supreme Court judgment handed down on 19 March 2014 and that the ruling is integrated into decision-making about patients.⁷⁰

Restriction and restraint

When a person lacks capacity to consent to care or treatment, Part 1 section 6 of the MCA defines restraint as the use, or threat to use, force to secure the doing of an act which the person resists, or restricting a person using the service's liberty of movement, whether or not that person resists. Staff can exercise restriction and restraint if they reasonably believe it is necessary to prevent the person coming to harm and that it is a **proportionate** response to the likelihood of the person suffering harm and the seriousness of that harm.

Hospitals will wish to ensure that:

- staff understand the legal framework around restriction and restraint, in particular that they are able to justify it as being in the person's best interests and proportionate to the likelihood of harm, and that it is used for the shortest period of time possible
- staff are trained in the use of restriction and restraint techniques
- records are kept when the use of restriction/restraint has been used
- restriction and restraint practice is audited regularly and where improvements are identified an action plan to implement them is developed
- staff have access to guidance on the distinction between restriction and restraint, and deprivation of liberty.

If staff reasonably believe that the extent of restriction and restraint required in delivering care and treatment, in the best interests of a person using the service, goes beyond what is allowed under Part 1 paragraph 6 of the MCA and towards deprivation of liberty, then it must be specifically authorised. The next section deals with this in more detail. **A key responsibility of the person responsible for the care of each individual person who uses services is to identify if this is the case and where required prepare the application for authorisation for sign-off by the approved senior member of staff.**

When to seek authorisation

Knowing when to complete a form 4 and seek authorisation for a potential deprivation of liberty is not always straightforward. Hospitals are not required to know exactly what is or is not a deprivation of liberty, only to be alert to when the situation **might** be a deprivation. Courts have recognised that often this point can be a matter of opinion, and it is the assessment process commissioned by the supervisory body that determines whether a deprivation of liberty is occurring or not.

There is anecdotal evidence that some people have a mistaken belief that seeking and receiving an authorisation is in some way a stigma for the relevant person or the institution caring for them. There is also the view that because around half of applications are approved, an application not being approved is in some way a criticism of the hospital.

It should be remembered that the purpose of the process is to protect the rights of vulnerable people and ensure they are not deprived of their liberty unnecessarily and without representation, review or right of appeal.

The assessment process itself is a protection of the relevant person's rights irrespective of the outcome. The outcome supports the rights of the relevant person and assures the hospital that the care regime is in that person's best interests.

Each case should be judged on its own merits with the assessment procedure considering the following questions:

- Why do I reasonably believe the person lacks the mental capacity to agree to the restrictions or restraint in place? (For example, a formal capacity assessment has been undertaken and recorded.)
- Is the relevant person free to leave (whether they are trying to or not) the institution when they want to?
- Is the relevant person subject to continuous control and supervision?
- Is the care regime the least restrictive option available?
- Is the care regime in the relevant person's best interests?

If a person lacking capacity to consent to the arrangements for their care and treatment is subject both to continuous supervision and control AND not free to leave they are deprived of their liberty.

It may not be a deprivation of liberty, although the person is not free to leave, if the person is not supervised or monitored all the time and is able to make decisions about what to do and when, that are not subject to agreement by others.

A hospital is far more likely to face criticism and potential legal action for practising deprivation of liberty without the appropriate authorisation than it would if it made application for authorisation in circumstances that were subsequently found not to be a deprivation.

As a matter of good practice, service providers should seek to reduce the necessity for urgent authorisation of deprivation of liberty (form 1) by planning ahead as part of good care planning practice. Given the likely profile and the circumstances in which an authorisation might be sought, providers should be able to plan ahead. This allows for a full and proper assessment to be undertaken prior to any authorisation coming into force. However, it is accepted that this will not always be possible in cases of emergency or crisis.

What is deprivation of liberty?

This resource is not a review of the case law since 2009. It does, however, provide assistance in making decisions about when an application should be made. The DoLS Code of practice¹² gives guidance in Sections 2.5 and 2.17 to 2.24. However, a hospital should consider the Supreme Court's 'acid test' when determining whether a deprivation of liberty is occurring; namely, is the person who lacks capacity to consent to being in hospital kept under continuous supervision and control, and are they free to leave? Other questions to consider include:

- Is the care regime more than mere restriction of movement?
- Is the person being confined in some way beyond a short period of time?
- Is the care regime the least restrictive option available?
- Is the care regime in the person's best interests? (Even if it is, it may still be a deprivation of liberty requiring authorisation.)
- Is the person being prevented from going to live in their own home, or with whom they wish to live?

Hospitals should note that a person's compliance with, or lack of objection to, their care and support in hospital is not relevant to whether it amounts to a deprivation of liberty.

The courts have found that deprivation is a matter of type, duration, effect and manner of implementation rather than of nature or substance.¹³ In simple terms, confining a person in their room, sedating them or placing them under close supervision for a very short period may not be a deprivation, but doing so for an extended period could be. However, what might appear to be mere restriction and restraint, such as a locked door, if repeated cumulatively, could also amount to a deprivation.

Section 2.5 of the DoLS code of practice¹⁴ gives some examples of what could constitute deprivation of liberty, drawn from a range of court cases:

- restraint is used, including sedation, to admit a person to an institution where the person is resisting admission
- staff exercise complete and effective control over the care and movement of a person for a significant 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 consider it appropriate
- a request made 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 (for example, subject to one-to-one supervision).

Staff need to keep constantly in mind the question 'Why do I reasonably believe this person lacks capacity?', and regularly check the evidence.

Hospitals need to take the above pointers into account when determining whether the restriction and/or restraint being applied to a person who lacks the capacity to consent to their care and treatment, in their best interests, moves towards deprivation of liberty which then requires authorisation. Deprivation of liberty could be occurring if one, some or all the above factors are present. Hospitals should work closely with the local authority's supervisory body, or DoLS team, so that any cases of doubt are immediately identified and discussed.

While parties should work closely together it remains the responsibility of the hospital to decide on the need for an assessment and to submit an application. Supervisory bodies should not be asked to 'pre-screen' potential applications.

It is generally better practice to err on the side of caution and make an application if it is believed that the level of restraint, or repeated frustration of a person's wishes, could amount to a deprivation of liberty.

Working with people who use services

When the hospital is making a DoLS application, it should inform the relevant person plus any close family or carers. The hospital has a duty to identify if someone is without friends or relatives who are able and willing to be consulted as part of the assessment process, and to inform the supervisory body of this on the application form. The supervisory body would then appoint an IMCA under Section 39A of the MCA. The IMCA would then support the person being assessed and ensure they are involved in the process as much as their abilities allow.

An important role within the Safeguards is that of the relevant person's representative, generally a family member or friend of the person, who has the right to request a review of any of the qualifying assessments, and to challenge an authorisation with an application to the Court of Protection, on behalf of the person. If the relevant person cannot choose their own representative (or there is not relative or friend available and willing to undertake the role), and if there is no person with a lasting power of attorney allowing them to choose a representative, the best interests assessor will nominate a person for the role. The assessor will generally identify a possible relevant person's representative who would be asked to carry out this role. The relevant person's representative must be able to keep in contact with the person: if the representative is a friend or relative, they have the right of access to an IMCA for help in challenging the authorisation if they so choose.

This is advocacy support and not legal representation, though paid and unpaid representatives do have a crucial role in challenging authorisations to the Court of Protection.

Once an authorisation has been granted, it falls to the hospital to inform and support the person being deprived of their liberty and their representative on matters relating to the authorisation. The following are examples of good practice adopted by many hospitals:

- working with and supporting the relevant person and their representative to ensure they understand what an authorisation means in relation to care and treatment, leaving the hospital, etc.
- ensuring they are aware of their right to request a review of the authorisation at any time
- having available for them information on local formal and informal complaints procedures
- supporting the relevant person and their representative in understanding their right of challenge to the Court of Protection (under Section 21A of the MCA)

which would be legally aided, perhaps using the hospital's patient advice and liaison service

- being aware that in the case of disputes the expectation is that the public body involved, generally the NHS hospital or, in the case of private hospitals, those hospitals or the relevant local authority, would take the matter to the Court of Protection
- being aware of the entitlement of the relevant person and their representative to the support of an IMCA (who would be appointed by the supervisory body)
- monitoring whether the representative maintains regular contact with that person and supporting them in doing so.

As the period of the deprivation of liberty progresses the hospital should:

- Monitor the case carefully.
- Set out in the care plan roles and responsibilities in relation to the deprivation of liberty plus details of any conditions attached to the authorisation and how these will be implemented and monitored.
- Keep a record of all actions taken in respect of any such conditions.
- Request a review from the supervisory body should the conditions need to change.
- Inform the supervisory body of any changes in the situation such as the person leaving hospital, any conditions attached to the authorisation needing to change, or the person's presentation significantly changing in some way. In such circumstances the supervisory body will, upon notification by the hospital (or by the relevant person's representative), undertake a review and the hospital should work closely with the supervisory body to ensure the review is conducted swiftly.
- Keep copies of applications and authorisations with the relevant person's notes.
- Maintain appropriate records of the relevant person's care and treatment during the period of the authorisation.
- Be aware that they must not deprive a person of their liberty any longer than necessary, and cease doing so if appropriate, even in advance of the supervisory body formally ending the authorisation.

Example from practice

Mr B, an 89-year-old widower living alone in a bungalow, was admitted to an acute hospital for a planned knee replacement operation. Following surgery he was transferred to a rehabilitation ward. He had a range of health problems, from chronic kidney disease to osteoarthritis, with some evidence of memory problems and confusion

Mr B was agitated and confused after his operation, trying to get out of bed and walk, when he was unable to. Subsequently he continued to demand to leave.

Since he was making repeated requests to leave and staff were preventing this, an urgent authorisation was issued followed by a standard authorisation. This was granted for three weeks, to allow time for a best interests decision and care plan to be put in place, ready for Mr B to leave hospital.

However, this did not happen within the three weeks and a further standard authorisation was requested.

Hospital medical and social work staff then told the best interests assessor that Mr B would be 'unsafe' to return home due to his cognitive impairment, and that a likely placement would be an elderly mentally infirm residential setting. Although Mr B had no previous contact with community mental health services, he was now prescribed drugs to reduce aggression and agitation. A capacity assessment, carried out by a medical student, had found Mr B to lack capacity, but there was no evidence of this relating to specific decisions as required in the MCA, and the diagnosis appeared to rely heavily on his score on a Mini-Mental State examination.

When asked by the best interests assessor, his nephews stressed Mr B's independent nature, and thought he would be much happier at home than in a care setting. They pointed out that Mr B had a supportive network of neighbours, and that his GP had no worries about him before this hospital admission.

The mental health assessor reported that Mr B was 'better than they described' and would have scored more highly on the Mini-Mental State examination when he saw him, despite some word-finding difficulties and cognitive impairment, probably caused by a dementia-like condition.

Mr B showed little insight into his needs, but expressed his strong desire to be at home rather than 'fussed over' in residential care: he told both assessors that he had gone into hospital to get his knee fixed, not to be imprisoned, and that he hated having no choice left in his life.

The best interests assessor concluded it was in Mr B's best interests for the deprivation of liberty to continue in the **very** short term, while a discharge plan was being implemented. Conditions for the authorisation included a second opinion about the prescription of antipsychotic drugs, and that, in the light of the marked improvement in his mental state following the time immediately post-surgery, the hospital should make every effort to improve Mr B's ability to decide for himself how he should live.

At a best interests meeting the following week, attended by Mr B and his nephews as well as staff from the hospital, the GP surgery and the local authority, a decision was made that Mr B should return home with a care package, which he successfully did.

Working with IMCAs

In certain circumstances the relevant person being assessed for an authorisation will be entitled to the support of an IMCA, appointed by the supervisory body. In some cases the IMCA will continue working with the relevant person through the period of the authorisation and subsequent reviews.

Hospitals will be familiar with working with IMCAs in relation to serious medical treatment decisions and people who use services staying in hospital for 28 days or more, who lack capacity and appear to have no family or friends apart from paid carers. It is important that hospitals work with DoLS IMCAs in the same way they would with an IMCA in any other circumstances.

‘No contact’

There may be occasions 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. A relatively common scenario is where a family member may be putting pressure on a person to sign cheques or other financial papers when they no longer have the capacity to do so. Another example may be where a well-meaning relative is bringing in food which the person is no longer able to eat safely, putting them at risk of choking.

A result might be a suggestion or a decision by a hospital or local authority staff member that the person should not have contact with the named individual. This is a serious matter, a human rights issue which requires consideration of less restrictive ways of addressing the problem. Preventing contact is always a last resort, and the Code of practice suggests that it is the Court of Protection which should be the arbiter in matters of ‘no contact’.

Hospitals should note that an authorisation under the Safeguards, other than as a very short-term measure, should not be relied upon to manage ‘no contact’ cases and instead hospitals should seek a court decision.

Clearly such circumstances should be managed in close co-operation with the local authority’s adult safeguarding service. There is a risk the Safeguards could be used to inadvertently legitimise more general safeguarding concerns and this should be avoided.

Preventing a person from having contact and how this should be managed must feature in a hospital’s safeguarding policy and procedure. Preventing contact with family members may be a breach of a person’s human rights.

Mental health settings

Inpatient mental health settings are different from acute and community bed wards in that they are specifically designed for the compulsory detention of patients under the Mental Health Act (MHA). Hospitals will admit patients who satisfy the criteria for detention as set down in that Act and its own code of practice.¹⁵

If the hospital wishes to admit patients lacking capacity to give consent to admission without a detention under the MHA they would need to **demonstrate that the care**

regime for those not detained under the Act is distinct and different from that for those who are detained under the Act. Otherwise there is a risk that a person who lacks the capacity to consent, even if they are not objecting to their care and treatment, is likely to be deprived of their liberty by simply being in that setting.

For patients in inpatient mental health units who are subject to DoLS, staff should be guided by the relevant legislation and code of practice, and the advice on good practice contained in that document.

Generally a person who is resisting being a mental health patient and is admitted to a unit registered to accept detained patients for the treatment of a mental disorder should be subject to the relevant section of the MHA.

The wider MCA and the MHA 2007 (1983) as amended are outside the scope of this resource. The CQC report, 'Monitoring the Mental Health Act in 2011/12'¹⁶ (pp 34–35) highlights both the scale of de facto detention of notionally voluntary patients and, allied to this, staff confusion about their legal status, an example being where:

'One member of staff described the patient as being 'on' a section 5 of the Mental Capacity Act. When the Commissioner explained that no-one can be 'on' a section 5 of the Mental Capacity Act, and that the powers of that Act cannot, in any case, authorise deprivation of liberty or detention, the member of staff said that the patient was 'sort of detained'. This demonstrates how potential confusion about the powers of the Mental Capacity Act can be increased through imprecise use of language to describe patients' legal status.'

It is important that mental health units are clear about the legal status of patients and with regard to DoLS know the criteria for applying the Safeguards and how this is different from informal status and detention under the MHA.

Example from practice

Mrs S (89) is a widow who lives alone. She has a diagnosis of vascular dementia. Her relatives noted that she was very independent and proud, and despite refusing support, managed in the community due to strict routines. One night, the police found her wandering in the street very confused and very cold, so they took her to a hospital where she was admitted to a medical assessment unit.

She banged the doors trying to get out, and assaulted nursing staff. She was diagnosed as suffering from an infection, and treatment with antibiotics was started. A mental health assessment concluded she was not detainable under the MHA and the managing authority gave itself an urgent DoLS authorisation and applied for a standard one.

The best interests assessor concluded that Mrs S did not have the mental capacity to make care, treatment and or risk decisions or decide where she should live at the present time.

The assessor recommended a short term DoLS authorisation, with conditions to enable medical and social care assessments to be concluded, and a best interests meeting to be arranged. The assessor anticipated that, following treatment for the infection, Mrs S's confusion could lessen, leading to consideration of her returning home and the protection of her Article 8 rights.

Human rights-based practice

Hospitals and the organisations managing them may find the following suggested guidelines helpful.

- The organisation has a **named person with responsibility for ensuring and promoting MCA-compliant practice**. This person should be a resource for information and the commissioning of training, and check that policies and procedures relating to people who might lack capacity are clear and are followed.
- **This person has an active working relationship and regular meetings with the supervisory body** which manages DoLS in the hospital's area. The staff managing the supervisory body or DoLS office can provide useful information and support to a hospital in meeting its responsibilities as a managing authority under the Safeguards.
- The hospital MCA lead ensures that the hospital has a **clear policy about who should sign urgent DoLS authorisations** and who should request standard authorisations. The MCA lead is **responsible for the monitoring and auditing** of both training and practice, to bring concerns about DoLS or wider MCA compliance to senior management in a timely way.
- The hospital has clear **policies**, applying both to admission to any department (or transfer between departments), and during a person's stay in hospital, **about action to take when a person appears unable to consent to treatment** or to being in the hospital.
- **Ward staff should be able to identify when there are concerns about a person's capacity** to consent to or refuse the proposed treatment and follow the MCA guidelines as well as their own hospital's policy and procedures.
- **Clinical governance mechanisms** are in place to ensure compliance with the MCA. Identified senior managers should receive regular information about all incidents of restraint of a person lacking capacity to consent to what is proposed, staff response, including mechanisms for learning from the incident, and assurance that staff action was the least restrictive of the person's rights that could be identified.
- **Restriction and restraint** are not 'blanket policies' but identified for an individual relevant person and very frequently revisited in an attempt to reduce or remove the restraint and ensure it is the least restrictive option.
- Staff understand when and how to raise concerns that a person may be deprived of their liberty.
- Data on requests for a standard authorisation under the Safeguards are studied and **possible gaps in appropriate use are identified and examined**.

- **Data on use of urgent authorisations are examined to identify possible less restrictive options:** if a request for a standard authorisation, accompanied by an urgent authorisation, is refused, staff learning from that experience is facilitated.
- **Care planning for people who might lack capacity is MCA compliant:** staff understand how and when to make best interests decisions, and the importance of consultation with family or friends interested in the person's welfare.
- If a person is facing a decision about serious medical treatment or where to live, lacks capacity to make that decision, and has no appropriate family or friends able and willing to be consulted as part of the decision-making process, **staff in all wards/departments know how to request an Independent Mental Capacity Advocate (IMCA)**^{17,18} to be part of the best interests decision-making process. It is a local authority responsibility to commission the service, but the IMCA can – and in relevant situations must – be instructed by NHS staff.
- Data are collected on IMCA referrals, and **audit procedures are used to identify circumstances of failure to instruct an IMCA** in circumstances when that omission could be unlawful.
- As part of monitoring quality and patient experience, **the MCA lead meets annually with the IMCA provider** for feedback on how decisions are being made regarding people lacking capacity to consent.
- Steps are taken to gather information about the experience of people who use services from family members and wherever possible from users who have experienced MCA principles being applied in practice.

The role of CCGs

This section looks at the roles and responsibilities of CCGs as commissioners of MCA-compliant services. It gives examples of the evidence CCGs could ask for from services and how the standard contract could support MCA compliance.

The HSCA 2012 determined that CCGs take on responsibility for commissioning the majority of local health care. All such health care has to be MCA compliant.

CCGs are required by their authorisation process to have a named MCA lead, together with relevant policies and training¹⁹ The CCG's MCA lead has primary responsibility on behalf of the CCG for ensuring that it commissions appropriate health care, in compliance with the MCA, for those adults normally resident within the area who may not have the capacity to consent to treatment even if that treatment is received in another area. The CCG is responsible for ensuring that all the services it commissions for people aged over 16 demonstrate compliance with the MCA and, for hospital care

for people aged over 18, DoLS. CCGs receive funding to support understanding and implementation of the MCA.

As part of the commissioning process, CCGs could reasonably expect to see evidence of the following from hospitals providing care to adults who lack capacity to consent to the arrangements for their care and treatment in hospital.

- Written evidence of MCA-compliant capacity assessments and best interests decision-making.
- Evidence that each hospital has an MCA lead.
- Evidence that hospital staff have knowledge of DoLS and know how to identify restrictions that may mean that a deprivation of liberty is likely to be occurring or may occur, and that an application for authorisation may be required. Sight of summary reports on induction, training and refresher training records will help with this.
- Copies of local policies and procedures covering training, access to and completion of requests for standard authorisations (form 4), urgent authorisations (form 1) and situations in which they can be used.
- A schedule of senior staff authorised to sign urgent authorisations and requests for standard authorisations, prior to submission to the supervisory body.
- Arrangements for training on restriction and restraint and associated record-keeping with particular reference to person-centred care that moves towards deprivation of liberty.
- Evidence of how the hospital involves the relevant person and their family and carers in the decision-making process.
- Evidence from audit covering use of the Safeguards, with explanation of figures from individual departments that appear particularly high or low. Benchmarks could be set using NHS Digital and CQC data and working in partnership with the supervisory body.
- Copies of extracts from CQC reports relating to compliance with the MCA, including DoLS.
- Arrangements for automatically reviewing care plans in circumstances where a best interests assessor finds a relevant person subject to a deprivation of liberty regime which is found not to be in that person's best interests.
- Records of compliance with the hospital's statutory duty to report DoLS authorisation applications and their outcomes to the CQC.
- Evidence of the involvement of clinical governance processes in best interests decision-making.
- A report from the board on the treatment of people lacking capacity.

- Information on how often and in what way the hospital seeks legal advice in relation to the Court of Protection.
- Evidence that the Safeguards feature in reports relating to vulnerable people and those with dementia, acquired brain injury or learning disabilities.
- Evidence that the Safeguards are linked into the hospital's systems and processes relating to improving people who use services' experience and the quality of their care and treatment.
- Evidence hospitals have integrated the Supreme Court judgment of 19 March 2014 into practice.

In addition, CCGs (probably through their own MCA lead's membership of a local MCA and DoLS multi-agency forum) will want regular meetings with their local supervisory bodies, which hold information on the numbers and outcomes of applications for assessment being submitted by hospitals. This could alert the CCG to potential concerns if, for example, a hospital whose patients have learning disabilities or dementia has a low number of applications compared to other similar hospitals.

Local and regional implementation networks should invite CCG MCA leads in their area to join them as part of promoting and sharing good practice and improving DoLS compliance.

The standard contract and mental capacity

CCGs will be familiar with the standard contract and the template it provides to guide commissioning decisions. Although it does not have a specific section in relation to people who lack capacity, MCA leads in CCGs can request the commissioning board to develop such a section if they wish, as the standard contract is updated annually.

In the meantime, MCA leads can use the following sections and ask hospitals to report on these specifically in relation to people who lack capacity:

- **Service condition 9: policy on consent.** Does this policy address in detail how people who cannot consent will be identified, who is responsible for carrying out assessments of capacity and who is trained and expected to carry out best interests decisions?
- **Service condition 1: all services will be compliant with the law.** How does the hospital board assure itself that the hospital is compliant with the MCA? What information does it collect and what does it monitor?
- **Service condition 12: service user involvement.** How does the hospital board assure itself that the experiences and views of those who lack capacity and their families are specifically recorded and acted on?
- **Service condition 13: equality of access and non-discrimination.** How does the hospital board demonstrate that it meets its obligations under the Equality Act 2010? Can it show that people with dementia or learning disabilities are receiving the same quality of treatment and care as others?

- **General condition 5: hospitals are required to demonstrate they have staff with appropriate experience, skills and competencies.** How does this relate to knowledge of the MCA and DoLS?

The standard contract is there to support commissioners. Commissioners can ask for information in specific sections in relation to specific groups of people (for example, people with dementia); they can ask commissioning support units to identify how to monitor activity and quality for people who lack capacity; they can use monthly monitoring of service meetings to raise questions and concerns. The standard contract and the DoLS indicators above give CCGs a framework for commissioning compliance with the MCA and the Safeguards.

Finally, CCGs will wish to work with local authorities to achieve successful delivery of the Safeguards. The local authority will commission six assessments, one of which can only be undertaken by a doctor. Each application requires assessments to be undertaken by a mental health assessor. These would usually be supplied by a mental health provider. CCGs should, working in partnership with the local authority, commission from their mental health provider the supply, training and release from other duties of suitably qualified doctors to undertake mental health assessments for the DoLS process.

Use of DoLS in care and nursing homes

Introduction

This section applies to all registered care and nursing homes whether in the public, private or charity sector and irrespective of the groups of residents they may care for, such as older people, those with dementia, learning disability or acquired brain injury, and irrespective of how placements are funded.

The DoLS have been in operation since 1 April 2009 and care homes and nursing homes will be familiar with the Safeguards, the Regulations,³ the DoLS code of practice, associated guidance and forms.²⁰ Many will have experience of making applications, the assessment process and putting into practice an authorisation.

There are estimated to be some 450,000 people in care and nursing homes in England and Wales at any one time and it is estimated that 70–80 per cent may have dementia.²¹ Many will be unable to consent, in whole or part, to their care and treatment.

In 2015–16, 195,840 deprivation of liberty applications were made, and a little over 105,000 assessments were completed. In 76,530 (73 per cent) of these, the deprivation was authorised. Of the applications, over 150,000 came from care homes. These figures compare with the roughly 11,000 applications made annually in hospitals and care homes combined prior to the 2014 Supreme Court judgement.⁵

However, the need to use the Safeguards in an individual home may be infrequent. It is, therefore, important that homes keep themselves familiar with the Safeguards to avoid unlawfully depriving a resident of their liberty or conversely letting a person come to harm when use of the Safeguards might have protected them.

Application of the Safeguards is variable across England. The reasons for this are unclear but it may suggest that the Safeguards are not being fully embedded in organisations or that training is inconsistent. A report on the use of the Safeguards highlights the range of training and awareness, as well as wide variations in practice concerning who can sign an urgent authorisation to deprive a patient of their liberty.²²

As a general guide, any home caring for people with dementia, with a mental illness, with a learning disability or with an acquired brain injury should be familiar with the Safeguards. This is irrespective of the person's age once they reach adulthood (18 years) and whatever method is used to fund their care.

Example from practice

Mr and Mrs S, both in their 90s, have been married for 70 years and are devoted to each other. She has dementia, and is very dependent on her husband for physical care; she lacks capacity to understand her care needs, and is anxious if separated from him.

Following a fall she was admitted into respite care. She was not badly hurt, but when her husband asked to take her home he was refused: this was because he persistently refused services and support (apart from their family, most of whom lived some distance away), and therefore safeguarding issues had been raised. The care home gave itself an urgent authorisation under DoLS. At the start of the assessment process it was clear that the home staff were convinced that Mrs S could never return home. In the formal assessment process that followed, they were made aware of the devastation caused to both Mr and Mrs S by these breaches of their human rights (her Article 5 right to liberty, their joint Article 8 right to a private and family life) and their view of the risks to her became more balanced within a more holistic assessment of Mrs S's best interests.

A short period of authorisation was agreed with a condition that the care providers were committed to working with Mr S to enable his wife to return home. To strengthen his position, he was named as his wife's representative under the Safeguards, so he felt able to visit often and advise on her care. The supervisory body appointed an IMCA under the DoLS provisions to help him understand his rights of challenge. He agreed to accept a care package at home, and Mrs S returned home, where she lived happily for a further nine months.

Organisations need to be reminded that DoLS do not provide authority to deprive a person of their liberty in a setting other than a hospital or care/nursing home and any such cases (for example, where a person may be deprived of liberty in their own home) should be referred to the Court of Protection for determination.

The CQC provides guidance for providers on both the MCA and, within this Act, DoLS. It is important that providers are familiar with this guidance and use it to judge whether they are meeting their duties and responsibilities under the Act. Links to both guides are given in the 'Useful links' section. The CQC also looks for evidence of compliance with the MCA and with the Safeguards in both its regular and thematic inspections.

The Bournemouth judgement

The Safeguards were introduced to provide a legal framework around deprivation of liberty, to protect some very vulnerable people. Specifically, they were introduced to prevent breaches of the ECHR such as the one identified by the judgement of the European Court of Human Rights in the case of *HL v. the United Kingdom*²³ (commonly referred to as the 'Bournemouth' judgement, from the name of the hospital involved). The case concerned an autistic man (HL) with a learning disability, who lacked the capacity to decide whether he should be admitted to hospital for specific treatment. He was admitted on an informal basis under the common law in his best interests, but the decision was challenged by HL's carers, who asked to take HL home and were refused.

In its judgement in 2005 the Court held that this admission constituted a deprivation of HL's liberty in that:

- the deprivation of liberty had not been in accordance with ‘a procedure prescribed by law’ and was, therefore, in breach of Article 5(1) of the Convention
- there had been a contravention of Article 5(4) of the Convention because HL had no means of applying quickly to a court to see if the deprivation was lawful.

Care and nursing homes are required to respect the human rights of their residents as set out in the HRA 1998 and in the case of HL the relevant right states: ‘Everyone has the right to liberty and security of person. No one shall be deprived of his or her liberty save ... in accordance with a procedure prescribed in law’ and ‘everyone ... shall be entitled to take proceedings by which the lawfulness of his or her detention shall be decided speedily by a court and his or her release ordered if the detention is not lawful’.²⁴

The majority of DoLS situations today occur in registered care and nursing homes.^{25,26} To prevent further similar breaches, the MCA 2005 was amended to provide safeguards for people who lack capacity specifically to consent to treatment or care in either a hospital or a care/nursing home that, in their own best interests, can only be provided in circumstances that amount to a deprivation of liberty. Later sections of this resource provide guidance on identifying when a deprivation of liberty may be occurring.

Winterbourne View and Mid Staffordshire Hospital

The circumstances of HL’s care are not isolated. Reports into care at Winterbourne View and Mid Staffordshire Hospital, and indeed other reports and inquiries, have highlighted issues relating to the care and treatment of vulnerable people where their basic human rights have not been recognised and people have been neglected and harmed as a result.

Similarly, the annual monitoring report by the CQC on the Safeguards²⁷ highlights the use of restraint and restrictions in care and nursing homes, without staff demonstrating a full understanding that these *are* restraints and restrictions and may well constitute a deprivation of liberty and require the Safeguards to be used.

For the avoidance of doubt, the Safeguards do not authorise care that would otherwise be recognised as abusive and an application should not be seen as an indication of this. Care homes should regard an application as showing that they understand their duty to uphold the rights of residents in care and nursing homes and that they are seeking an authorisation in the best interests of the person concerned.

The Safeguards are just part of the framework within which homes should be working to ensure they respect the human rights and dignity of residents. This framework is set down in law and includes:

- Human Rights Act 1998
- Mental Capacity Act 2005
- Disability Discrimination Acts 1995 and 2005
- Equalities Act 2010

Although this resource only covers deprivation of liberty it should be seen as part of a wider statutory framework aimed at improving the quality of the experience of residents in homes.

DoLS and the experience of people who use services

Applying the Safeguards should not be seen as a last resort for 'very difficult residents'. The Safeguards should be part of a continuum of positive actions taken by care home managers and staff to address the quality of experience in a care or nursing home. Managers will review and promote access to activities provided in the home, access to the garden or the local shop, to public facilities and to family outings or visits. Where residents are not included and so have little or no access to liberty or to choose their activities, they may require the protection of the Safeguards.

The Safeguards are central to improving the experience of residents whose liberty is restricted to the extent it may become a deprivation. They are part of a succession of measures a home would normally take to protect and promote the rights of residents. They should, therefore, be part of an organisation's quality improvement programme covering policy, audit, staff training, information for residents and relatives, relative involvement, reporting and benchmarking. How the Safeguards are managed and implemented should form part of the home's governance programme.

DoLS and the MCA 2005

The Safeguards are part of the MCA and cannot be effectively applied unless care home staff and managers are familiar with the Act, have received appropriate training and had their practice audited. The five statutory principles set down in Part 1 paragraph 1 of the Act equally apply to a resident for whom the Safeguards might be relevant:

- **a presumption of capacity:** every adult has the right to make their own decisions and must be assumed to have capacity to do so unless it is proved otherwise in respect of each specific decision
- **individuals must be supported whenever possible to make their own decisions:** a person must be given all practicable help before anyone treats them as not being able to make their own decisions
- **unwise decisions:** just because an individual makes an unwise decision, they should not be treated as lacking capacity to make that decision
- **best interests:** an act done or decision made under the Act for or on behalf of a person who lacks capacity must be done in that person's best interests
- **less restrictive option:** the person acting on behalf of a person who lacks capacity should consider all possible options that are less restrictive of that person's basic rights and freedoms.

It may be useful for managers and staff to discuss how each of these principles can be applied, promoted and championed in their care and nursing homes. It is helpful to make a list of all the decisions that residents can make, as well as a list of the different

ways that staff can support people to make as many decisions as possible. A system of recognising staff who make these principles a reality, even for the most confused or challenging residents, will help to ensure the quality of the service.

The less restrictive option is particularly important in relation to the Safeguards. For example, if a resident in a home is prone to restless walking, risks getting lost and coming to harm, and is also persistently trying to leave the building, staff should discuss whether an authorisation under DoLS might be required. Staff need to consider the steps they should take that both protect the resident from harm while at the same time ensuring their actions are the least restrictive option possible, ensuring the resident's basic rights and freedoms.

Applying DoLS in practice

As part of a home's quality improvement and governance arrangements there should be a framework in place that promotes the effective use of the Safeguards. (For the purposes of the legislation, a home considering an application for a deprivation of liberty authorisation is known as a 'managing authority').

This framework should include:

- **Staff training** on the Safeguards (as part of wider MCA training) so that staff know how to assess for deprivation of liberty when care goes beyond restriction/restraint and towards deprivation. This training should feature in induction, training and refresher programmes and records of completed training should be kept.
- **An MCA and DoLS policy and procedure** with particular reference to sections relating to training (some local authorities provide multi-agency DoLS training and homes should contact their local authority for more information), levels of responsibility, access to and completion of requests for standard authorisations (form 4), urgent authorisations (form 1) and situations in which they can be used.
- A schedule of senior staff authorised to sign off applications.
- **Guidance on care planning** which should feature the Safeguards and explain how they support an effective care plan and are not a substitute for good care planning
- **Arrangements for training on restriction and restraint** and associated record-keeping, with particular reference to care that moves from restriction and restraint towards deprivation of liberty. Staff should be sensitive to the relationship between restriction and restraint and deprivation of liberty and aware that whenever restriction is being used or considered it could actually be a deprivation of liberty. If the restraint might go beyond that authorised by Part 1 paragraph 6 of the MCA, the manager should assess whether an application to the supervisory body should be made.

- A policy on how the home involves the resident (the relevant person) and their family and carers in DoLS decision-making.
- **A programme of audit work covering application of the Safeguards** to identify areas that can be improved such as training, senior staff rotas for authorising urgent applications and general awareness.
- The follow-up of comments in CQC reports relating to compliance with the MCA and DoLS so that action is ensured.
- **Arrangements for automatically reviewing care plans** in circumstances where a best interests assessor finds a relevant person subject to a deprivation of liberty regime which is not in that person's best interests. It is important staff are aware of this.
- Priority given to the duty to report DoLS authorisation applications and outcomes to the CQC
- **A policy to clarify and determine where responsibility lies for the preparation and review of care plans**, and to ensure those leading this work are aware of the Safeguards and the role they play in care planning.
- **A policy on working in partnership with the local authority supervisory bodies** and supporting assessors on access to records and seeing the relevant person and their family/carers (taking account of the statutory right of assessors and IMCAs to see relevant records).
- **Maintenance of a supply of application forms** plus staff knowing where to locate them (forms can also be stored electronically, and obtained from any supervisory body).
- An awareness among staff responsible for care plans of the importance of meeting any conditions attached to an authorisation.
- A policy covering what action to take when an authorisation is coming to an end or needs to be reviewed.
- Patient and relative/carer information leaflets that include the Safeguards, local procedures and who to contact for more information.

Registered homes should be aware that the legislation expects them to scrutinise the care plan to ensure that it is the **least restrictive option** reasonably available and that any restriction or restraint is both necessary to prevent any likely harm and proportionate to that harm. Risks should be examined and discussed with family members. The risk of getting lost in the local area, the risk of spilling a cup of tea or the risk of getting out of a wheelchair need to be explored in terms of what can be done to lower the risk while weighing up the benefits of greater freedom and self-determination.

It is particularly important that homes have a clear policy and procedure in relation to which staff are authorised to make a DoLS application and that staff are trained and supported in this role. Depriving a person of their liberty is not a decision that should be

taken lightly, even if it is in that person's best interests. Homes should, therefore, have a procedure for agreeing who is authorised to sign applications. This is to ensure that there is an awareness at senior level when restraint is being implemented and is not intended to discourage an application for an authorisation. The list should be formally reviewed by care and nursing homes on a regular basis.

A person authorised to sign off applications should be involved each time an application is being prepared.

DoLS and the care plan

An authorisation to deprive a resident of their liberty is part of that resident's care plan and not a substitute for it. The care plan should be put together in accordance with the framework set out in the MCA 2005 and follow what the Act and subsequent case law say about capacity and best interests assessments. The duty in the Act to consult with appropriate persons with an interest in the welfare of the resident involved equally applies to the Safeguards.

Care and nursing homes need to record and consider a person's wishes and feelings in their care plans. Care plans should not simply be about what is done 'to' a resident, but also reflect the resident's wishes and preferences.

Care plans should explain how a resident's liberty is being promoted. Even small amounts of liberty and autonomy may mean a lot to residents in care and nursing homes, and different things will be important to different people. For example, a male resident may have a strong preference to be shaved by a male member of staff. Other residents may value highly the ability to receive a newspaper of their choice, or look forward to an occasional visit to a pub or simply the freedom to get up and go out.

Care plans should also show how residents are assisted to maintain contact and involvement with their family and friends.

Working with supervisory bodies

When a home wishes to seek a deprivation of liberty authorisation it will send the relevant paperwork to the appropriate supervisory body, which is the local authority where the person is normally resident, and which is paying for their care (or, if a person has funded their own care, the local authority where the care home is situated).

Homes will wish to work with their local authority to establish clear lines of communication and cooperation. Each local authority will have a DoLS office. Homes should:

- keep contact information for their local authority DoLS office
- have a procedure agreed with the local authority that allows assessors to have access to the resident in question, their family, carers and records
- understand that DoLS assessors have a statutory right to access relevant residents' notes
- ensure staff know their organisation's procedure for arranging a deprivation of liberty authorisation, including ways to ensure data protection

- have a supply of application forms 1 and 4 (or the local versions) available and ensure staff know where to locate them.

Case law

The case law relating to the Safeguards is evolving all the time and interpretation can be challenging. It is important that homes have access to reliable sources of information and guidance on case law developments so they can be applied to local practice where necessary. Homes will wish to ensure that any directly employed or contracted legal advisers are up to date on MCA judgements made by the courts and that processes exist for feeding the learning from these into practice.

The supervisory body may be able to provide case law updates and advice, and the Notes section provides links to sources. If a care home manager is unsure whether to make a referral for the Safeguards or not, it is generally better to err on the side of caution and make the referral.

It is essential homes are aware of the Supreme Court judgment handed down on 19 March 2014 and that the ruling is integrated into decision-making about residents.⁷⁰

Restriction and restraint

Where a person lacks capacity to consent to care or treatment, Part 1 paragraph 6 of the MCA defines restraint as the use, or threat of use, of force to secure the doing of an act which the resident resists, or restricting a resident's liberty of movement, whether or not they resist. Staff can exercise restriction and restraint if they reasonably believe it is in the person's best interests, necessary to prevent the resident coming to harm and that it is a **proportionate** response to the likelihood of the resident suffering harm and the seriousness of that harm.

Restriction and restraint can be physical, chemical or verbal but it must always be a proportionate response to prevent the possibility of the resident coming to harm and must always be the least restrictive option available in the circumstances, to avoid the risk of criminal prosecution.

Homes will wish to ensure that:

- staff understand the legal framework around restriction and restraint
- staff are trained in the use of restriction and restraint techniques
- records are kept when restriction or restraint has been used
- restriction and restraint practice is audited regularly and where improvements are identified an action plan to implement them is developed
- guidance is given to staff on the relationship between restriction and restraint and deprivation of liberty.

If staff reasonably believe that the extent of restriction of movement and restraint required in the best interests of a resident may go further than what is permitted under Section 6 of the MCA, and might amount to a deprivation of liberty, then the home must have clear policies and procedures in place to ensure that an application for authorisation under the Safeguards is submitted to the appropriate supervisory body as

soon as practicable. The next section covers this in more detail. **A key responsibility of the person responsible for the care of each individual resident is to identify a possible deprivation of liberty and prepare the application for sign-off by the approved senior member of staff.**

When to seek authorisation

Knowing when to seek authorisation for a potential deprivation of liberty may appear daunting. Although the Supreme Court's 'acid test' brought a good deal of clarity, knowing the actual tipping point between restriction and restraint and deprivation of liberty in an individual case is not always easy. Courts have recognised that often this point can be a matter of opinion.

However, a home only needs to consider that a resident's care **might** constitute a deprivation rather than trying to decide if it definitely does. A home is not required to understand the issue about the tipping point in great detail. If the proposed care may, in the home's judgement, constitute a deprivation of liberty it should make application. In cases of doubt the home should seek advice from the appropriate supervisory body's DoLS office.

Ultimately it is the supervisory body which decides if a deprivation of liberty is occurring and whether, if so, it meets the necessary criteria of being in the person's best interests, the least restrictive option that can be identified, and proportionate to the risk of harm to the person and the seriousness of that harm. If all the criteria are met, the supervisory body (local authority) issues the necessary authorisation.

It is not the role of the DoLS office to prejudge or screen a potential application. It remains the responsibility of the managing authority to decide whether a deprivation of liberty may be occurring and to submit an application for an assessment.

There may be occasions when a home is required to grant itself an urgent authorisation (created generally using form 1, but consult your local DoLS team for local advice). For example, a resident who has been assessed as lacking capacity to choose where they live may be objecting very clearly to being placed at the home and may be trying to leave. The person may not respond to distraction, and it may have been assessed that the risk of the person leaving is too great to permit them to go. In this situation the care or nursing home should have policies and procedures in place to enable staff to identify when an urgent authorisation is needed. The responsible manager, or a designated deputy, may then grant the urgent authorisation, which will be valid for up to seven days, and should understand how to then complete the accompanying standard authorisation application.

It appears, anecdotally, that appropriate application of the Safeguards is sometimes resisted due to a mistaken belief that seeking and receiving an authorisation is in some way a stigma for the individual involved or for the home or the staff caring for them. There may also be a view that, because around half of applications are approved, the failure of an application is in some way a criticism of the home involved.

It should be remembered that the purpose of the process is to protect the rights of vulnerable people and to ensure they are not deprived of their liberty unnecessarily and without representation, review or right of appeal. The assessment process

undertaken by the assessors and the local authority is itself a protection of the resident's rights, irrespective of the outcome. Assessors examine the person's needs and their situation in detail and in the light of the law. This assessment process is a protection, both for the staff, the home (which may be authorised to continue the care or advised to vary it through conditions or change some of it) and, most importantly, the resident and their family.

Whatever the outcome, a DoLS referral supports the rights of the relevant person and ensures that the care regime is in that person's best interests. **For this reason homes should err on the side of caution and submit applications if they believe deprivation of liberty might be occurring.**

Account also needs to be taken of the advice in paragraph 2.16 of the DoLS code of practiceⁱ. Each case should be judged on its own merits with the home's assessment procedure considering the following questions:

- Why do I reasonably believe the person lacks the mental capacity to agree to the restrictions or restraint to which they are subject?
- Is the relevant person free to leave (whether they are trying to or not) the home?
- Is the relevant person subject to continuous control and supervision?
- Is the care regime the least restrictive option available?
- Is the care regime in the relevant person's best interests?

If a person lacking capacity to consent to the arrangements for their care and treatment is subject both to continuous supervision and control AND not free to leave they are deprived of their liberty.

It may not be a deprivation of liberty, although the person is not free to leave, if the person is not supervised or monitored all the time and is able to make decisions about what to do and when, that are not subject to agreement by others.

Although there is no need to submit 'blanket applications' covering many or all residents, a home is more likely to face criticism and potential legal action for practising deprivation of liberty without the appropriate authorisation than it would be if it made applications for authorisation in circumstances that were subsequently found not be deprivation.

What is deprivation of liberty?

It is good practice for care and nursing home providers to seek to reduce the need for urgent authorisations (see above) by planning ahead as part of good care planning practice, in the light of the likely profile of residents and the circumstances in which an authorisation might be sought. This allows for a full and proper assessment to be undertaken prior to an authorisation coming into effect.

This resource is not a review of the case law since 2009. It does, however, set out the steps to help make a decision about when an application should be made. The Code of practice²⁸ gives guidance in Sections 2.5 and 2.17 to 2.24. A care home should consider the Supreme Court's 'acid test' when determining whether a deprivation of

liberty is occurring; namely, is the person who lacks capacity to consent to being in hospital kept under continuous supervision and control, and are they free to leave? Other questions to consider include:

- Is the care regime more than mere restriction of movement?
- Is the person being confined in some way beyond a short period of time?
- Is the care regime the least restrictive option available?
- Is the care regime in the person's best interests? (Even if it is, it may still be a deprivation of liberty requiring authorisation.)
- Is the person being prevented from going to live in their own home, or with whom they wish to live?

Care homes should note that a person's compliance with, or lack of objection to, their care and support in hospital is not relevant to whether it amounts to a deprivation of liberty.

It should be emphasised that even if staff believe the care proposed for a resident to be in their best interests it could still amount to a deprivation of liberty requiring authorisation.

The courts have found that deprivation is a matter of type, duration, effect and manner of implementation rather than of nature or substance.²⁹ In simple terms, locking a person in their room, sedating them or placing them under close supervision for a very short period of time may not be a deprivation, but doing so for an extended period could be. However, what might appear to be mere restriction and restraint, such as a locked door, if repeated cumulatively, could also amount to a deprivation.

Section 2.5 of the DoLS code of practice also gives some examples of what could constitute deprivation of liberty, drawn from a range of court cases:

- restraint is used, including sedation, to admit a person to an institution where the person is resisting admission
- staff exercise complete and effective control over the care and movement of a person for a significant period
- staff exercise control over assessments, treatment, contacts and residence
- a decision has been taken 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 made 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 (for example, often subject to one-to-one care).

Staff need to keep constantly in mind the question 'Why do I reasonably believe this person lacks capacity?', and to be checking the answer.

Homes need to take case law into account when determining whether the restriction and/or restraint being applied to a resident, who lacks the capacity to consent to their care and treatment in their best interests, is moving towards deprivation of liberty which requires authorisation. Deprivation of liberty could be occurring if one, some or all the above factors are present. Registered homes should develop close working relationships with the DoLS team at the supervisory body and in cases of doubt seek advice. There is no need to request authorisation routinely for all residents, even if they do lack capacity, to stay in the home.

The general advice, however, is to err on the side of caution and make an application if the home believes deprivation of liberty may be occurring.

It is not the role of the DoLS office to 'pre-screen' potential applications. If a home believes a resident's care regime amounts to a deprivation of liberty it should submit an application to its supervisory body.

Working with residents

When an application is being made under the Safeguards, the home should inform the relevant person and the person likely to represent them, including close family or carers. The home has a duty to identify if someone lacks family or friends apart from paid carers, and to inform the supervisory body of this on the application form. The supervisory body will then appoint an IMCA to support the person being assessed under Section 39A of the MCA. The advocate will work to ensure the relevant person is involved in the process as much as possible, and will take an interest in whether the care is being provided in the least restrictive way that will meet the person's needs. However, the advocate is not a legal representative.

The supervisory body will also appoint a person to represent the relevant person. Generally, this will be a relative or friend, but if the person has nobody interested in their welfare apart from paid carers, the supervisory body will appoint a paid relevant person's representative.

Once an authorisation has been granted it falls to the home to support the person being deprived of their liberty and the relevant person's representative on matters in relation to the authorisation. The following are examples of good practice adopted by many homes:

- Working with and supporting the resident and their representative to ensure they understand what an authorisation means in relation to care and treatment and leaving the institution, etc.
- Ensuring that the person and their representative are aware of their right to request a review of any part of the authorisation at any time.
- Having available for them information on local formal and informal complaints procedures.
- Supporting them in understanding their right of challenge to the Court of Protection under Section 21A of the MCA. Such a challenge would be legally

aided (in the case of disputes over the authorisation, the expectation is that a public body will take the matter to the Court of Protection).

- Being proactive in relation to the relevant person's legal entitlement to the support of an IMCA.
- Supporting the resident's representative in ensuring they stay in touch with the resident.

As the period of the authorisation progresses the home should:

- monitor the person's wellbeing carefully
- set out in the resident's care plan roles and responsibilities in relation to the authorisation, plus details of any attached conditions and how these will be implemented and monitored
- keep a record of actions taken in relation to any conditions attached to the authorisation and any subsequent outcomes that may affect the care plan or the deprivation of liberty
- inform the supervisory body of any changes in the situation such as factors requiring the authorisation to be ended, a need to change the conditions or the resident's presentation significantly changing in some way. In such circumstances the supervisory body should be asked to undertake a review
- keep copies of applications and authorisations with the resident's records
- maintain appropriate records of the resident's care and treatment during the period of the authorisation
- be aware the home can remove an authorisation if it is no longer appropriate but must inform the supervisory body
- cooperate with the supervisory body when arranging reviews.

Working with IMCAs

In certain circumstances a relevant person being assessed for an authorisation will be entitled to the support of an Independent Mental Capacity Advocate (IMCA), appointed by the supervisory body.³⁰ In some cases the IMCA will continue working with the resident through the period of the authorisation and subsequent reviews.

Care and nursing homes should ensure that IMCAs are able to see and speak to the resident concerned in private and can access their records.

'No contact'

There may be safeguarding situations 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. For example, a family member may be thought to be putting pressure on a resident to sign cheques or other financial documents when they no longer have the capacity to do so. Or a relative may be bringing in food which the

resident is no longer able to eat safely, putting them at risk of choking. In other instances, a relative may be perceived as 'interfering', 'questioning' or 'challenging' by staff.

In such circumstances a manager or local authority staff member might think that the person should not have contact with their relative or friend. This is a serious matter, which requires consideration of less restrictive ways of addressing the problem. Preventing contact is always a last resort, and the MCA Code of practice,³¹ now supported by case law, suggests that it is the Court of Protection which should always make decisions when contact between family members or close friends is being restricted, and it is impossible to solve the situation through mediation.

Homes should note that an authorisation under the Safeguards, other than as a very short-term measure, should not be relied upon to manage 'no contact' cases and instead a court decision should be sought.

There is a risk that the Safeguards could be used inadvertently to legitimate general safeguarding concerns and this should be avoided. Clearly such circumstances should be managed in close co-operation with both the local authority's adult safeguarding service and its DoLS office.

Preventing contact with family members and friends may be a breach of a person's human rights, and as such it should feature in the home's safeguarding policy and procedure.

Human rights-based practice

These are some suggested indicators of success that homes may wish to adopt.

- The home has a **named person with responsibility for ensuring MCA compliant practice**. This person should be a resource for information and the commissioning of training, and check that policies and procedures relating to people who might lack capacity for some decisions (such as those concerning consent, how to assess capacity and how to make a best interests decision) are clear and are followed.
- **This person has an ongoing working relationship with the supervisory body** in the home's area: their staff can provide useful information and support to a home to help it meet its responsibilities as a managing authority under the Safeguards.
- The home's MCA lead should ensure the home has a **clear policy about who should sign urgent authorisations** and who should request standard authorisations.
- **The MCA lead is also responsible for monitoring and auditing training and practice**, and bringing concerns about DoLS or wider MCA compliance to senior management in a timely way.

- **The home has clear policies, applying both to admission and during a person's stay**, about action to take when a person appears unable to consent to treatment and care, or to being in the home.
- **Staff know how and when to assess and record a person's capacity in accordance with the MCA**. There is evidence that they do their best always to maximise the person's capacity to make their own decisions.
- **Governance mechanisms are in place to ensure compliance with the MCA**: identified senior managers receive regular information about all incidents of restraint of residents lacking capacity to consent to what is proposed, including the staff response, mechanisms for learning from the incident and assurance that staff action was the least restrictive (of the person's rights) that could be identified. Staff need guidance on circumstances when restriction and restraint moves towards deprivation of liberty.
- **Restriction and restraint are not 'blanket policies' but are identified for an individual person** and are frequently revisited in an attempt to reduce or remove restraint and to ensure care is provided using the least restrictive option principle.
- Staff recognise and understand when, how and to whom to raise concerns that a person may be deprived of their liberty.
- Data on requests for a standard authorisation under the Safeguards are studied and gaps in appropriate use identified.
- **Data on use of urgent authorisations are examined to identify possible less restrictive options**: if a request for a standard authorisation, accompanied by an urgent authorisation, is refused, staff learning from that experience is facilitated.
- **Care planning for people who might lack capacity is MCA compliant**: staff understand and are competent in how and when to make best interests decisions, and comply with the requirement to consult with family or friends interested in the person's welfare.
- If an IMCA is appointed to support a person subject to a DoLS authorisation assessment, the home works with and supports that person.
- Steps are taken to gather information from family members and, wherever possible, from residents themselves regarding **their experiences of the MCA and DOLS process** even though they may lack, or have lacked, capacity.

Example from practice

When his wife died, Mr Q (90) came into a care home from the smallholding where they had lived for many years. He was incommunicative, and staff thought him very suspicious of them, and somewhat confused. They found Mr Q very resistive to bathing and showering; in their words, 'It was a battle to get him to keep clean or change his clothes.' He also worried them by wanting to go out alone. Although he was quite mobile, there were concerns that he might get lost, and the home had twice notified the police, who had found Mr Q several miles away, but saying he knew his way back to the home. Mr Q's daughter-in-law supported the staff's actions in restraining him, saying he'd always been 'difficult'. The care home became worried that the battles were getting worse, and applied for a standard authorisation.

The best interests assessor identified that Mr Q had capacity to refuse their interventions: Mr Q explained that he wasn't used to bathrooms, and preferred to wash at the sink. He also thought they were being nosy asking him where he was going, and wanting him to change his clothes so often – he resented the implied criticism. He thought he was unlikely to fall, but he would take that risk: he couldn't bear being indoors or with other people all day.

Mr Q was then invited to help staff draft his care plan, which, with his input, consisted of minimal intervention, more stews at dinner time and acceptance from the staff that he was free to wash how he wanted, wear what he wanted, and go for long walks.

Local authorities: commissioning for compliance

Local authorities are required to comply with the MCA and the European Convention on Human Rights. When commissioning services for vulnerable people, each local authority will wish to assure itself that the service provider is respecting residents' rights and, in respect of the MCA and DoLS, applying good practice. The indicators below will go some way to providing this assurance and are part of the commissioning team's tool kit aimed at ensuring residential care is of the highest quality.

As part of the commissioning process, local authority commissioning teams should expect to see evidence of the following from homes providing care to adults who lack capacity to consent to the arrangements for their care and treatment while in the home:

- That the organisation has a named MCA lead.
- That policies and procedures place the MCA at the heart of decision-making.
- That there are written MCA-compliant capacity assessments and best interests decision-making is taking place.
- That care plans document people's wishes and feelings and identify what homes are doing to promote residents' liberty.
- That care plans show how homes promote access to family and friends.
- That staff have knowledge of the Safeguards and know how to identify restriction that may go beyond that which is authorised under Part 1 paragraphs 5 and 6 of the MCA and which, therefore, could lead to criminal

prosecution unless specifically authorised (via DoLS or the Court of Protection).

- That there is a written schedule of senior staff authorised to sign urgent authorisations and applications for standard authorisations.
- That arrangements are in place for training on restriction and restraint and associated record-keeping with particular reference to care that moves towards deprivation of liberty.
- That the home involves the relevant person, their family and carers in the decision-making processes
- That audit records give details of use of the Safeguards, with explanation of figures that appear particularly high or low. Homes can use the NHS Digital annual report and data from their supervisory body to set benchmarks.
- That the home has in place arrangements for automatically reviewing care plans in circumstances where a best interests assessor finds a relevant person subject to a deprivation of liberty regime which is found not to be in that person's best interests.
- That the home keeps records of compliance with its statutory duty to report DoLS authorisation applications and their outcomes to the CQC.
- That any restriction on contact with family members is discussed with the local authority DoLS team to seek advice about whether the situation needs referring to the Court of Protection.
- That the Supreme Court judgment has been integrated into practice.

The commissioning team will also need to have access to copies of local policies and procedures covering training (including refresher training), along records of the number of requests for standard authorisations (form 4), urgent authorisations (form 1) and the circumstances which lead to applications being made.

In addition, the team will work with their local authority's DoLS office, which will have information on the numbers and outcomes of applications for assessments being submitted by homes. This could alert commissioners to potential concerns if, for example, a home whose residents have learning disabilities or dementia has a low number of applications compared to similar homes.

The appropriate supervisory body will be governed by the Department of Health's (DH) ordinary residence guidance.

Supervisory bodies: roles and responsibilities

Introduction

The DoLS code of practice³² is invaluable for understanding the roles and responsibilities created by these Safeguards.

The role of the local authority to act as a supervisory body for DoLS imposes upon it a more general duty to act as a human rights champion for those adults who might lack capacity to agree to actions taken by others.

The role of human rights champion entails the active promotion of the human rights of citizens – for example, in avoiding breaches of their human rights wherever possible, and facilitating their ability to contest actions of the local authority in court.

When a local authority is carrying out its supervisory functions, it is essential that its processes and practices promote human rights, are open, transparent and helpful to the person at the centre of DoLS, the ‘relevant person’ (or person for whom detention is sought), and their relatives or friends. The ‘positive obligation of the state’ means that all its interventions must be accompanied by scrutiny within this essential framework.

Process should be lawful, consistent and accurate:

- people subject to a request for authorisation to deprive them of their liberty must be informed about the request, and have its implications explained
- they must also be clearly advised how to challenge the authorisation.

What makes a good supervisory body

Oversight and management of the supervisory body functions relating to the Safeguards should be assessed against the standards laid down in the funding fact sheet produced by the DH in 2012.³³ Due to their importance, indicators of quality that make for a good supervisory body are here quoted from that Factsheet:

Structural governance

- There is clarity about who holds corporate responsibility for MCA/DoLS functions.
- Those holding corporate responsibility are supported to have a good understanding of the Safeguards, including relevant case law.
- There is clarity that the supervisory body needs to be independent of service delivery.
- Unauthorised deprivations of liberty are managed according to an agreed and time-sensitive protocol.

Regulatory compliance

- There is a good understanding of and compliance with regulations.
- Assessors are trained, supervised and commissioned in accordance with regulatory requirements.
- Information is available on how many times a managing authority has been asked to extend an urgent authorisation and the reasons for this.
- Local authority contracts with relevant care homes specify compliance with the DoLS regulations.

Awareness and use of case law

- There is evidence that case law decisions are incorporated into assessments, authorisations and training.

Monitoring and evaluating the DoLS process

- There is an agreed system, including frequency, for monitoring and evaluating implementation of the DoLS process.
- There is an independent element to monitoring and evaluation, for example involvement of peer authorities or IMCAs.
- The results of the process are shared with identified senior management and concerns addressed.
- Regulatory compliance is monitored and the reasons for any defaults are explored.
- Information is collected on frequency, timeliness and outcomes of reviews.
- Unauthorised deprivations of liberty are shared with management, commissioning and safeguarding teams.

Empowerment of the individual within the DoLS process

- There is evidence that the relevant person has been empowered and assisted to share their views.
- There is evidence that the person's wishes and feelings have been listened to and actively considered as key components of each assessment and review.
- Capacity and best interests assessments record attempts made to maximise residual capacity and give the person as much involvement in arrangements for their care and treatment as possible.

Reviews

- The DoLS service is certain that the relevant person (if able) and their representative understand that they can request reviews of any of the assessments at any time.
- The DoLS service makes it easy for the person, their representative, the managing authority or a third party to ask for a review – for example, by accepting telephone requests in the first instance.
- The DoLS service proactively offers reviews whenever the person or their representatives, assessors, the managing authority or an IMCA acting under the relevant sections of the MCA (39A, 39C or 39D) expresses disquiet.
- The DoLS service has a policy of sending different assessors from those who initially assessed the situation to undertake reviews.
- Information is available on how many reviews are requested, how many carried out, and how many result in changes such as lifting an authorisation.
- Outcomes from reviews are monitored and where necessary the DoLS service liaises with other services such as commissioning or safeguarding.

Partnership working

- There is evidence of good relationships/partnerships with the relevant person, their representative and IMCAs carrying out roles under Section 39 of the MCA.
- The DoLS office provides relevant information and support to the relevant person's representatives and IMCAs to make it easier for them effectively to carry out their roles.
- The supervisory body checks with the managing authority that the role of the relevant person's representative is being fulfilled to the required standard.
- Support is offered to the relevant person's representatives who may have difficulty fulfilling some of the requirements of the role.

- The supervisory body scrutinises the appointment of the relevant person's representative to ensure that the person has been given the opportunity to choose their own representative if possible, and that, failing that, and in the absence of lasting power of attorney, the selection is transparent and justified.
- MCA Section 39D IMCAs are commissioned for each authorisation granted, to support the person and their representative to understand the terms and any conditions of the authorisation and to challenge the authorisation if they wish.

Feedback and learning for local authorities and CCGs

It is important that learning from the DoLS process and outcomes is fed back into mainstream care via the commissioning and contracting process as a way of continuously improving the care of vulnerable people and protecting their rights. Specific pointers to good practice include:

- learning gained from the assessment and processes of DoLS about avoidance of deprivation of liberty is identified
- supervisory body authorisers share this learning as appropriate with care management and commissioning services
- data on DoLS activity is shared and used within organisations.

Feedback and learning for managing authorities

- Learning should be fed back in order to improve the care offered in managing authorities (both care homes and hospitals).
- Learning gained from managing the Safeguards becomes part of MCA training provided for managing authorities or shared with their learning and development managers.
- There are clear mechanisms to facilitate learning in managing authorities, such as notifications of training events, or a newsletter with examples of good practice.

Joint local strategic leadership

- Local authorities, CCGs, hospital clinical governance teams and the CQC have explicit joint aims regarding implementation of the MCA including DoLS.
- This leadership provides clear shared messages on the importance of using a human rights framework within both health and social care.
- There are multi-agency forums to facilitate relationships and the ongoing implementation of the MCA including the Safeguards.

Compliance with the legal and regulatory framework

The DoLS are sometimes criticised for being too bureaucratic. However, those working within this area often find that the forms, and their instructions, provide invaluable reminders of the MCA Schedule A1 and the Regulations.³⁴ The forms and their framework of guidance prompt staff to ensure the independence and appropriate skill and training of assessors, tell administrators what information they need to share with whom, and lay out essential questions for consideration by assessors.

Some authorities have edited and altered the forms for ease of use (for example, by combining forms 1 and 4, so that a managing authority does not have to repeat information on two forms required to be completed at the same time). It remains advisable that the administrative framework provided by the forms should be the basis for good practice as it ensures compliance with the legislation and also facilitates the maintenance of appropriate record-keeping.

With the move by the Health and Social Care Information Centre (now NHS Digital) towards individual data-collection,³⁵ it is advisable for supervisory bodies to ensure that, where necessary, an individual can be tracked through a series of authorisations.

Amid reorganisation of government forms and guidance, it is good practice for supervisory bodies to ensure that they have copies of the most up-to-date forms easily available – for example, on the local authority website and/or sent proactively by email to hospitals and care homes thought likely, on the basis of their populations, to need them.

For the regulatory framework, including selection and training of assessors, see the ‘Deprivation of liberty safeguards: regulations and assessor training’.³⁶

Timescales: good practice

An urgent authorisation is generally in force for up to seven calendar days. Although it is challengeable, it should be in force for as short a period as possible, since it is an authorisation to deprive a citizen of their liberty without a proper assessment process. There are occasions when a supervisory body may ask the managing authority to extend the period, as it is permitted to do, for a maximum of a further seven calendar days. However, this must be for some exceptional reason, and expressly **not** simply for the convenience of the supervisory body. Section 6.24 of the DoLS code of practice³⁷ states:

It is for the supervisory body to decide what constitutes an ‘exceptional reason’, but because of the seriousness of the issues involved, the supervisory body’s decision must be soundly based and defensible. It would not, for example, be appropriate to use staffing shortages as a reason to extend an urgent authorisation.

Example from practice

Mr T, a widower of 74, lives in a care home. He has dementia. His only relative in this country is his daughter Jane. Following a stroke, Mr T's confusion increased, and he began leaving the home, even climbing out of windows, because he thought his mother was calling him. The care home believed it was depriving him of his liberty by repeatedly preventing him from leaving, so gave itself an urgent authorisation and requested a standard one. The best interests assessor discovered that Jane T was a police officer currently on night duty. She had never heard of the Safeguards, and greatly wanted to be part of the assessment process for her father. The urgent authorisation was extended for two days until her shift pattern changed and it was possible for her to be at the care home when the best interests assessor visited.

Since the huge increase in deprivation of liberty applications following the March 2014 Supreme Court ruling, timescales for standard authorisations have been routinely missed, sometimes by considerable margins, as supervisory bodies have been inundated with application requests. In 2015–16, only 29 per cent of applications were completed within the standard of 21 days, compared to an average of 98 per cent in the year leading up to the Supreme Court ruling.⁵

Audit

It is important for local authorities to audit the performance of their supervisory body functions to ensure that statutory timescales are clearly recorded and met, and that assessments are of a quality to enable authorisers to understand how the assessors reached their conclusions.

Applications from hospital managing authorities, which were formerly disposed of by primary care trusts, should be explored by the local authority supervisory bodies to ensure understanding of their culture relating to restraint, and to investigate differences in application rates among hospitals. This is a possible use of some of the additional funding given to local authorities to carry out the functions formerly undertaken by primary care trusts.

Assessors

Support

All assessors under the Safeguards must undergo mandatory annual refresher training. Some authorities have developed further systems to support assessors, often based on those required for approved mental health professionals (AMHPs) working within the MHA 1983. The CQC pilot study showed that some supervisory bodies have gone further than others in training assessors for their roles:

Three [supervisory bodies] have a regular reapplication process. Three require attendance at one-to-one meetings (supervision); one undertakes annual appraisals of the assessor's best interests assessor or mental health assessor practice; three require attendance at regional meetings. One requires that assessors must have completed at least one assessment each year to remain current. One requires an annual DBS check (formerly known as Criminal Records Bureau check). There is a wide variation in requirements in relation to

assessor CPD. About half of the supervisory bodies showed a relatively structured approach to requiring and checking on assessor CPD; three made very few demands and checks. CQC plans to explore this further.

Recruitment and retention

The CQC study also explored practice in relation to recruitment and retention of assessors. An interesting 'negative finding' was that the methodology was less successful in gathering information about mental health assessors, who are in general either employed by local mental health trusts or independent practitioners, than about best interests assessors, who are more often employed directly by local authorities. It is possible that this reflects a degree of disengagement from mental health assessors on the part of local authority supervisory bodies. Following the transfer of supervisory body responsibility from primary care trusts to local authorities there has been a risk that supervisory bodies may not always have access to sufficient mental health assessors with relevant specific areas of expertise (such as dementia or learning disability).

The study showed that most supervisory bodies directly employ most of their best interests assessors, while resorting to self-employed contractors when, for example, facing challenging timescales or a rush of concurrent applications. From this sample, just one used self-employed best interests assessors exclusively.

Support for managing authorities

- It is not appropriate for a supervisory body to influence, or seek to influence, the managing authority with regard to making a request for authorisation. The supervisory body, however, can and should encourage managing authorities to consider making a request for authorisation if advised to do so by others, in particular, people who use services/residents or their relatives.
- Supervisory bodies act correctly when they request a managing authority to consider in a timely fashion whether to ask for further authorisation relating to a person who is already on an authorisation. In such a situation, the managing authority must either request a further authorisation period, or, if the current authorisation is no longer necessary, request the supervisory body to carry out a review of whichever qualifying requirement is no longer met.
- A managing authority should not allow an unnecessary authorisation to run on, sometimes for a considerable period, until it reaches its end-date. Supervisory bodies should encourage managing authorities to examine closely the need for existing authorisations. Since they should be doing everything possible to lessen the need for an authorisation, managers might reasonably expect that these attempts would create a situation where the person no longer needs to be restrained in the way that was authorised. If this happens, they must stop restraining the person (since it is no longer necessary in the person's best interests), and request a review from the supervisory body.

- When giving information on the process, and on what case law and the DoLS code of practice² suggest as possible pointers towards a deprivation of liberty, a supervisory body must take care to avoid bypassing the lawful assessment process by pronouncing an opinion on a situation presented by a managing authority.
- A managing authority must be advised that, if they are in any doubt about whether or not current or planned restrictions might amount to a deprivation of liberty, they should request authorisation so that the assessors can examine all the features of the person's care.
- It is good practice to give assistance to managing authorities to ensure they understand how to complete urgent authorisations and requests for standard authorisations, and the requirements that they must:
 - inform the relevant person (orally and in writing) of their rights to challenge the authorisation or to request a review
 - inform them and their representative of their right to have the help of an IMCA (under MCA section 39D) and how to have one appointed
 - give information to the representative as soon as is practicable after giving it to the relevant person.

It is also good practice to ensure that the managing authority understands its responsibility to notify the CQC of the authorisation request and outcome, and that they know how to do this.

Example from practice

One supervisory body provides detailed individual feedback to managing authorities on all requests made. It also sends a regular newsletter to all managing authorities.

Examples of proactive practice

- Rather than wait for the managing authority to request a further authorisation, many supervisory bodies notify them formally a month before the expiry of a current authorisation (or in good time if the authorisation is shorter than this), and discuss with them whether they think another authorisation is needed or whether the circumstances of the person have changed, so that they are no longer being deprived of their liberty (in which case they must be advised to request a review).
- Some supervisory bodies provide ongoing briefing sessions for local managing authority staff (hospitals as well as care homes).
- Some supervisory bodies target 'likely candidates' (such as homes specialising in dementia or where residents have learning disabilities and

challenging behaviour) where the Safeguards are not being invoked and visit them to explain how and when they should consider their use.

The CQC pilot found that 10 out of the 13 supervisory bodies interviewed offered some kind of planned, continuous support to managing authorities in relation to the MCA in general and the Safeguards in particular:

Of these, seven offered telephone support throughout the working day. Two offered an e-learning course, two others gave individual feedback to applicants after each request for authorisation; four analysed applications and gave specific remedial training to applicants where needed ... One supervisory body stood out as working in a number of ways to help the managing authority understand their role and meet requirements relating to it, including making sure they understood any conditions.

When an authorisation comes into effect

A standard authorisation comes into force when it is given, though it may be given in advance (within a month) of being required (see MCA Schedule A1³⁸ 50–53.) An authorisation is 'given' when it is signed by the authoriser and communicated to the managing authority, since only then does it come into existence. Case law has clarified that an authoriser's role is:

- to scrutinise with rigour the grounds for the authorisation
- to add or remove conditions and shorten the authorisation period as required
- to request if necessary further information from the assessors to support their decision-making.

See also the 'Checklist for authorisers' in this resource.

Supervisory bodies should not tell managing authorities that an authorisation has been given before it has been signed, on the basis that the supervisory body office has had sight of the required written assessments and supports the authorisation.

Purpose of an authorisation

An authorisation can only be given with regard to somebody who lacks capacity to decide 'whether or not he should be accommodated in the relevant hospital or care home for the purpose of being given the relevant care or treatment' (MCA Schedule A1,³⁹ paragraph 15) and the person does not have an advance decision to refuse treatment (ADRT) and is not subject to a lasting power of attorney that would conflict with the proposed treatment. (MCA code of practice⁴⁰ 4.26).

An authorisation cannot be used by a local authority or NHS trust to 'get its own way', nor to prevent the relevant person having contact with relatives or friends. This is a clear breach of Article 8 of the Human Rights Act 1998, and cannot be authorised through the DoLS process. Such a situation, which has the potential to lead to a major dispute between family members and the local authority, must be the subject of urgent local mediation and, if this fails to achieve consensus, the local authority should speedily seek resolution from the Court of Protection.

Support for people who use services and their representative

It is essential that the relevant person, and their relatives or friends, are consulted and are at the heart of the process of assessment. Any concerns expressed by them about the care plan and the prospective authorisation should be taken with the utmost seriousness. Otherwise, it is impossible to assess how proportionate any restrictions are. If a best interests assessor is selecting a relevant person's representative, it is essential to remember that the purpose of the Safeguards is to ensure that the person, or someone acting on their behalf, can challenge the authorisation as laid down in the European Convention on Human Rights⁴¹ Article 5(4). It is a serious distortion of the role of a representative if someone is omitted from selection because it is known that they disapprove of the authorisation or it is thought likely they will challenge it. Indeed, some supervisory bodies proactively select from possible candidates the representative who disapproves of the authorisation as they are more likely to maintain a strong interest in the relevant person's human rights and the process itself.

As well as being crucial to the process, the relevant person and their representative must be sent information and copies of assessments, together with the outcome of all assessments and reviews.

Example from practice

Some supervisory bodies send out 'easy-read' explanations of the Safeguards to all people for whom authorisation is sought. If authorisation is granted, they send information to the representative, and also routinely make contact by telephone as well as providing the name of the manager of the Safeguards and their direct telephone line. They routinely refer all standard authorisations to the IMCA service under Section 39D of the MCA.

It is good practice to give the relevant person and their representative the contact details of a named person, such as the manager of the DoLS service, who can if necessary help them understand any aspects of the process they find bewildering. In selecting the relevant person's representative, the best interests assessor must remember that, if the person can choose for themselves, every effort must be made to enable them to do so (even if their choice is expressed simply).

Example from practice

Mr R has dementia. When the best interests assessor explained about the authorisation, and his right to choose someone to be his representative, he said: 'If you want someone to be on my side, you ask our Mabel; she's always been a good friend to me and won't let them mess me about.'

The supervisory body is in a good position, via the authoriser, to note issues of care management that should be shared with adult social care professionals or the contracts and commissioning team.

The use of IMCAs within the Safeguards

The Independent Mental Capacity Advocacy service is a crucial support for those at the heart of the process: the people deprived of their liberty in their best interests and their

families. IMCAs are provided by and accessible through the supervisory body. The IMCA role is an important safeguard to ensure that both the relevant person and their representative understand their rights when an authorisation is in place. The fifth annual IMCA report⁴² shows the range of usage among local authorities of Section 39D IMCAs. The report quotes the ADASS/SCIE good practice guide covering this area,⁴³ which recommends:

Supervisory bodies to instruct s39D IMCAs at the start of all standard authorisations where a person has a family member or friend appointed as their representative. This gives the person and their representative the opportunity to meet a s39D IMCA and so that they are in a better position to decide if they need the support of one at that point, or sometime in the future.

The Department of Health IMCA report⁴⁴ also shows an increase of 18 per cent from the previous year (2010/11) in the number of IMCA instructions associated with the use of DoLS. In total there were nearly 2,000 DoLS referrals to IMCA services in 2011/12.

The local authority has the responsibility to commission an effective and sufficient IMCA service within its boundaries as well as ensuring that sufficient assessors are available to carry out their required supervisory functions in a lawful and timely way.

A local audit of provision will highlight problems, including, for example, lack of sufficient IMCAs to work when required (see Appendix 1). Local authorities should ensure that management structures, in particular commissioning teams, are capable of responding to evidence of service delivery problems that may affect the local authority's ability to meet its supervisory functions.

Relationships with safeguarding teams

Following problems identified in case law, the CQC's pilot study of supervisory bodies⁴⁵ explored the relationships between supervisory bodies and adult safeguarding teams. It was found that 10 DoLS services were co-located with adult safeguarding teams, and shared staff over both functions. The remaining three had separate teams but shared a manager. The report comments:

On the face of it, the case for a link between the management of safeguarding and the Safeguards is attractive, but there are some risks. For smaller authorities in particular, the question is raised about how to maintain the conceptual distance between their safeguarding and their MCA (including the Safeguards) functions.

The approach taken by safeguarding teams tends to focus on protection from abuse, whether a person has capacity or not, whereas the Safeguards are a measure specifically located within human rights law to protect the human rights of people lacking capacity. While human rights should be and often is an important dimension to safeguarding and protection, some court cases have shown that professionals can focus on protection to the detriment of autonomy and rights, and fail sometimes to work within the best interests framework of the MCA.

In the same study, when asked generally about barriers to good practice, at least one respondent commented on 'lack of understanding among colleagues of the human

rights agenda as opposed to adult safeguarding'. Some local authorities have deliberately kept their DoLS teams separate and independent from safeguarding, while others ensure separation of decision-making rather than of location.

Lord Justice Munby has warned local authorities about the dangers of intervention against people's wishes and against their human rights. In a recent speech he expanded on this:

The local authority is a servant and not a master – a truth which on occasions is too easily overlooked. Vulnerable adults look to the state – to the local authority – for the support, the assistance and provision of services, to which the law entitles them. They do not seek to be controlled by the state or by the local authority. And it is not for the state, in the guise of the local authority, to seek to exercise such control.⁴⁶

As a result, one of the important roles of effective DoLS teams is to act as local authority scrutineers of safeguarding interventions when the interventions are against the wishes of people, or where they involve the control of compliant people who lack the capacity to agree to the intervention.

Example from practice

One local authority has introduced automatic referrals from safeguarding to the DoLS team when a person who lacks capacity is removed to a place of safety, and/or when there is significant interference with family relationships. The DoLS team decides whether and when an urgent application to the Court of Protection is necessary.

Core duties of the supervisory body

The core duties and responsibilities of the supervisory body are to:

- Respond to requests for standard authorisation.
- Respond to requests for an extension of an urgent authorisation.
- Commission the relevant IMCA service when required to do so.
- Commission the six assessments required for a standard authorisation.
- Grant the standard authorisation of deprivation of liberty if all assessments are positive, or not grant if one or more assessment is not met.
- Appoint the relevant person's representative.
- Respond to requests to review a standard authorisation and carry out a review when appropriate.
- Suspend and, where appropriate, terminate a standard authorisation if the person is detained under the MHA 1983 for up to 28 days (Schedule A1 of the MCA 2005⁴⁷ para. 93(2) does not specify who holds the responsibility to suspend the standard authorisation). The standard forms 14 and 15 issued for the suspension of standard authorisation and the lifting of the suspension are listed as forms for the managing authority to complete. This guidance follows paragraph 8.30 of the DoLS code of practice⁴⁸ which specifies that the

standard authorisation is suspended, and the suspension lifted, by the supervisory body.

- Terminate the deprivation of liberty standard authorisation when appropriate.
- Terminate the appointment of a relevant person's representative when appropriate.
- Respond to requests to investigate alleged unauthorised deprivations of liberty.

Equivalent assessments

An equivalent assessment is explained in the DoLS code of practice⁴⁹ chapter 4 (following MCA Schedule A1⁵⁰ paragraph 49) as an assessment carried out within the previous 12 months, not necessarily for the purpose of a deprivation of liberty authorisation, that meets all the requirements of a DoLS assessment, is still accurate, and of which the supervisory body has a written copy. (A common-sense exception to the 12-month time-limit is the age assessment, which has no time limit.). The code gives as an example a recent assessment carried out for the purposes of the Mental Health Act 1983, which could serve as an equivalent to a mental health assessment for DoLS purposes.

The CQC pilot study⁸ found a range of practice relating to the use of equivalent assessments:

- Eight (of the 13 respondents) would consider accepting an assessment that was up to a year old on a case-by-case basis, but one of these eight normally only uses assessments if they are less than six months old, and one only accepts assessments if they are less than three months old.
- Four said that they would always commission fresh assessments if there had been a change of circumstances since the last assessment; three said they commissioned fresh assessments for each application.

Good practice

With the exception of the age assessment, some supervisory bodies have formulated policies governing the use of equivalent assessments, in particular time limits on reusing assessments. These policies differ widely, from only using assessments carried out within the previous month, to reusing assessments carried out over 11 months previously. Although the Schedule allows for reuse of assessments carried out within the previous 12 months, it is generally agreed that the longer the period of time since the assessment was made, the more wary a supervisory body should be of reusing it rather than commissioning a fresh assessment. In particular, many supervisory bodies would only reuse a capacity assessment under very exceptional circumstances, referring to the requirement in MCA Section 2 that assessment of capacity must be decision- and time-specific. European case law suggests that, when using previous mental health assessments, supervisory bodies should be careful to ensure they provide evidence that the person's mental disorder still persists.

A supervisory body should take care to avoid any suggestion of 'rubber-stamping' repeat authorisations without revisiting the circumstances of the person. For example, a fresh, formal look at the mental health assessment might, while agreeing with the previous diagnosis of mental disorder, find differently in answer to a question about the effect of deprivation of liberty on the person's mental health.

Every time a repeat authorisation is requested, and the supervisory body is considering using equivalent assessments, it must consider whether the reuse of any of these might pose a risk to the relevant person's right to expect that any decision to deprive someone of their liberty is made following defined processes and taking all the current relevant factors into account.

Supervisory bodies should record the reasons why they have used any equivalent assessment: standard form 11 is recommended for this purpose.

Peer support

Most of the support available to supervisory bodies when the Safeguards were first implemented (such as regional leads and a dedicated DH team) no longer exist. However, many of the original regional groups have continued informally, and provide an invaluable source of advice and best practice in this area.

Several law firms and chambers of barristers put out free, regular updates on case law in this developing area, and there are national and regional conferences and masterclasses; it is essential for supervisory body management staff, managing authorities and best interests assessors to be aware of these.

When the CQC explored this area⁵¹ it found that, while seven of the 13 supervisory bodies were active participants in their regional MCA/DoLS network, one reported only informal contact with neighbouring authorities, and two reported no peer support contacts at all. It is recommended good practice for local authorities to support the DoLS manager to be actively involved with the regional group, as well as seeking out other mechanisms for their continued learning.

Emerging practice for supervisory bodies

A supervisory body can only authorise a deprivation of liberty if it takes place in a care home or hospital. If it takes place elsewhere, it can only be authorised by the Court of Protection. Authority can never be given under a Lasting Power of Attorney to make a deprivation of liberty lawful.

The community

There is a potential role for supervisory bodies in assessing whether a care plan or the care provided in the community to a person lacking capacity to consent might be approaching a deprivation of liberty. Their role is to examine the care plan and the care provided and to seek an assessment by a best interests assessor about whether a) there might be a deprivation of liberty; b) the care could be provided in a less restrictive way that removes the danger of the situation being a deprivation of liberty; and c) an application to the Court of Protection may be necessary.

Examples from practice

One local authority has its reviewing officers working very closely with the DoLS team. The reviewing officers refer clients who receive their care in their own homes or in other community settings to the DoLS office if they have concerns about restrictions. The DoLS office then sends out a best interests assessor to establish whether there may be a deprivation, whether it is in the person's best interests (or whether it could be made less restrictive) and whether an application to the Court of Protection is needed.

Another local authority has introduced procedures to ensure that particular care is taken in planning clear pathways for people with a learning disability at the point of transition to adult services. The restrictions which may be appropriate for a child may no longer be appropriate for a young adult and may amount to a deprivation of liberty unless challenged. Where such restrictions may be thought necessary in the person's best interests, and the person will be in a care home or hospital setting when they reach the age of 18, they require assessment and authorisation under the Safeguards. If the person is likely to be in supported living accommodation, or living in their own or the family home, deprivation of liberty can only be authorised through an application to the Court of Protection.

Wider local authority strategy based on learning from DoLS

DoLS teams, in particular best interests assessors and authorisers of DoLS, are becoming the key experts in care planning in a human rights framework. They are developing knowledge, skills and understanding which are relevant and important for the majority of social care people who use services. Local authorities could build on this expertise in developing their wider human rights strategy and practice.

Example from practice

Mr J (23) has learning disabilities and Asperger's syndrome, with behavioural difficulties including aggression when frustrated or anxious.

He was admitted in an emergency to a local residential care home, after a violent incident at home connected both to his problems and to his mother's mental health issues and substance abuse. The local unit was unable to manage his behaviour, so he was placed in a specialist home 50 miles away.

He lacked capacity at this time to consent to arrangements made by the home for his care. The staff in the unit brought him back in his pyjamas from several attempts to go home at bedtime, when he was missing his mum, and additionally refused to allow his mother to visit.

The unit gave itself an urgent authorisation and requested a standard one. The best interests assessor identified breaches of Article 5 and Article 8 of the Human Rights Act 1998 and decided that Mr J had been deprived of his liberty. She found the level of restriction to be disproportionate to the risk and seriousness of harm to Mr J and decided that this deprivation of liberty could not be authorised as it stood. She informed the commissioners of the service that a serious dispute between Mr J's mother and the unit should be mediated and, if intractable, referred rapidly, by the local authority, to the Court of Protection.

A formal best interests meeting was convened urgently. As part of this, contact between Mr J and his mother was reinstated, including facilitating visits from his mother to the care home. These visits were successful. A care plan was agreed that worked towards moving Mr J into a supported living setting, close to his mother's home. Care staff are now working to give him increased daily living skills and Mr J is no longer deprived of his liberty, but looking forward to a more independent lifestyle.

Assessors and assessments

Mental health assessment (standard form 4)

What makes a good mental health assessor

Mental health assessors must first of all meet the regulatory requirements of the MCA DoLS Regulations 2008.⁵² They must be medical doctors experienced in mental health: either approved under section 12 of the Mental Health Act 1983, or be registered medical practitioners with at least three years' post-registration experience in the diagnosis or treatment of mental disorder, such as GPs with a special interest. It includes doctors who are automatically treated as being section 12 approved because they are approved clinicians under the Mental Health Act 1983. They must have completed the standard training as laid out by the Royal College of Psychiatrists. Like best interests assessors, they must complete annual refresher training that satisfies the supervisory body of their fitness to continue to practice as a mental health assessor. Some supervisory bodies encourage mental health and best interests assessors to attend joint refresher training, often consisting of case-law updates, case scenarios, and discussions of recent local assessments that have raised issues of good, or poor, practice.

A good mental health assessor should have experience relevant to the person's condition. The supervisory body should consider whether, if possible, the use of a mental health assessor who knows the person professionally will be of benefit. Usually this will reduce the stress for the relevant person and the assessor may be best placed to assess them thoroughly. An assessor who has prior knowledge of the person may be better able to predict what effect deprivation of liberty would have on their mental health.

The local authority is responsible for ensuring that sufficient mental health assessors are available. A good relationship with local CCGs might enable authorities to initiate a dialogue with mental health services to encourage doctors approved under Section 12 of the Mental Health Act (particularly those with expertise with older people or learning disabilities) to train and practise as mental health assessors under DoLS.

Mental health assessors carry out assessments under the Safeguards in both care homes and hospitals. In some areas a small number of assessors do all – or almost all – of the appropriate assessment work for a range of local authorities. This situation carries some risk, as retirement or other events can lead to a sudden shortage of assessors. There is also a potential risk to the integrity of the Safeguards when the opinion and interpretation of a small number of assessors, however well informed, is relied upon. It may also become harder to identify a suitable different mental health assessor to carry out a review of previous assessments.

If local authorities identify problems in either the quantity or quality of mental health assessors, these should be discussed with the local CCG(s) and MCA lead(s).

The possibility and advantages of training as a DoLS mental health assessor can be promoted locally among, in particular, MHA Section 12 approved doctors working in the areas of older adults' mental health, learning disability and acquired brain injury. The advantages include an enhanced knowledge of human rights law in general and of

deprivation of liberty in particular, which will benefit people who use services while also updating the practitioners' essential knowledge. A business case for local or regional training might be presented for the use of joint local authority/CCG resources available for implementing the Mental Capacity Act.

What makes a good mental health assessment

Case law reminds medical assessors and supervisory bodies that for the lawful detention of a 'person of unsound mind' within the meaning of Article 5(1)(e) of the European Convention on Human Rights, a true mental disorder must be established before a competent authority on the basis of objective medical expertise. The mental disorder must be of a kind or degree warranting compulsory confinement and the validity of continued confinement depends upon the persistence of such a disorder.

Mental health assessors and supervisory bodies should be cautious that, if an equivalent assessment is used, they are certain that these criteria are met, in particular that they are sure the person's disorder has continued to be as it was previously described.

For the purposes of DoLS, the person meets the mental health requirement if suffering from mental disorder within the meaning of the Mental Health Act, but disregarding any exclusion for persons with learning disability. The MHA defines a mental disorder as 'any disorder or disability of the mind'. Although the Act does not define these terms any further, it is likely that conditions falling within the definition could include:

- organic mental disorders such as dementia, or personality and behavioural changes due to brain injury and damage
- mental and behavioural disorders due to psychoactive substance use, schizophrenia and other delusional disorders
- affective disorders, such as depression and bipolar disorder
- neurotic, stress-related and somatoform disorders such as anxiety, phobic disorders, obsessive compulsive disorders, post-traumatic stress disorder and hypochondriacal disorders
- eating disorders, non-organic sleep disorders and non-organic sexual disorders
- personality disorders, such as antisocial personality disorder, borderline personality disorder
- autistic spectrum disorder
- learning disabilities (but with the exception that, for the Safeguards, there is no need for this to be associated with abnormally aggressive or seriously irresponsible conduct).

As Section 4.33 of the DoLS code of practice⁵³ explains:

The purpose of the mental health assessment is to establish whether the relevant person has a mental disorder within the meaning of the Mental Health Act 1983. That means any disorder or disability of mind, apart from dependence on alcohol

or drugs. It includes all learning disabilities. This is not an assessment to determine whether the person requires mental health treatment.

The DoLS code of practice goes on to highlight the distinction between a mental **health** assessment and a mental **capacity** assessment:

- although a person must have an impairment or disturbance of the functioning of the mind or brain in order to lack capacity, it does not follow that they automatically have a mental disorder within the meaning of the Mental Health Act 1983
- the objective of the mental health assessment is to ensure that the person is medically diagnosed as being of 'unsound mind' and so comes within the scope of Article 5 of the European Convention on Human Rights.

When carrying out a mental health assessment, the standard form reminds the assessor to:

- (a) consider how (if at all) the relevant person's mental health is likely to be affected by him being a detained resident, and
- (b) notify the best interests assessor of his conclusion (Schedule A1 to the Mental Capacity Act 2005⁵⁴ paragraph. 36)
- (c) consult with IMCA under section 39A of the Mental Capacity Act if applicable.

If the person is being assessed for a second or subsequent authorisation, the mental health assessor should consider how the person responded to any previous period of authorisation. If the person shows little sign of being reconciled to the authorisation, it is important that the best interests assessor is fully aware of this, in order to decide whether the restrictions are proportionate to the risk and seriousness of harm, in the light of the person's evident unhappiness.

The Deprivation of Liberty Safeguards code of practice⁵⁵ reminds both best interests assessors and mental health assessors that it is a mark of good practice for them to discuss their findings and their opinions. In case of divergent opinions, this is particularly important: if the relevant person fails any assessment, the Safeguards cannot be used to protect their rights.

Example from practice

Isabel (28) has a mild learning disability, and suffered an accidental brain injury two years ago. Since the injury she has been very impulsive, putting herself at risk by rushing across roads, trying to jump out of cars and climbing out of windows. The triggers are usually pet animals or small children. She is being assessed for her second period of authorisation, in a specialist nursing home. The mental health assessor is concerned about the effect deprivation of liberty is having on Isabel's mental health: there are signs of depression, and Isabel's self-esteem appears lower than at the time of the earlier authorisation. She says nobody listens to her. The assessor explains his findings to the managing authority and the best interests assessor, and queries whether a less restrictive care plan, perhaps involving access to pets, is possible.

Checklist for mental health assessors

- The assessor is able to diagnose a defined mental disorder, with the assistance of clinical notes if available, or from interview and observation.
- If there is no formal diagnosis, the assessor is satisfied that there is a mental disorder as defined in the MHA, and has supported that opinion with description of relevant signs and symptoms.
- If there is a disorder, the assessor has described the signs and symptoms in sufficient detail to bear out the diagnosis.
- If the assessor considers that there is no mental disorder in the meaning of the Act, they have notified the supervisory body immediately, as there is no need for any further assessment to take place.
- The assessor has considered and described their opinion of the likely effect of a deprivation of liberty on this person's mental health, with reasons for that opinion.
- The assessor has informed the best interests assessor of their opinion of the likely effect of a deprivation of liberty on this person's mental health.
- The assessor has consulted with any IMCA appointed under MCA section 39A if applicable.
- The assessor has completed the form legibly, signed and dated it.
- The assessor will return the form to the supervisory body office, in a secure format, as soon as possible.

For an audit monitoring tool for mental health assessments, see Appendix.

Mental capacity assessment (standard form 4)

What makes a good mental capacity assessor

The assessor⁵⁶ must be eligible to be either a best interests assessor or a medical assessor. Consideration should be given to using an assessor who already knows the person if this is possible, since it is likely to reduce the stress of being assessed, and enable the relevant person to be at their most relaxed. The assessor should also have professional experience and knowledge of the possibly incapacitating disorder the person lives with – for example, learning disability, dementia, multiple sclerosis or acquired brain injury.

Example from practice

A supervisory body audited the skills of its best interests assessors and mental health assessors, and found a lack of expertise relating to acquired brain injury and neurological conditions. The governance group identified professionals with the appropriate skills and professional knowledge, and encouraged them to train in order to join the pool of assessors.

What makes a good mental capacity assessment

It is crucial for the assessor to be clear that they are assessing the person's capacity about a specific question whether or not he or she should be accommodated in this particular hospital or care home, for the purpose of being given some specific care or treatment.

Assessors must be clear that this is a separate assessment from that relating to the capacity to engage in contact with family and friends: a person may have capacity to decide who they want to socialise with, but lack capacity to consent to the question of accommodation in a care home or a hospital.

Section 4.29 of the DoLS code of practice⁵⁷ emphasises that 'the assessment refers specifically to the relevant person's capacity to make this decision at the time it needs to be made. The starting assumption should always be that a person has the capacity to make the decision'. Chapter 3 of the main MCA code of practice discusses in detail ways to empower people to make their own decisions. Any assessment of capacity must also demonstrate that every effort has been made to enable a person to make their own decision.

The assessment must give evidence, at every stage, of how the person was assessed for the two-part test, and which elements of the 'four functional tasks' they could not manage, even with every assistance and support given as required under the second principle of the MCA. (As described in the MCA code of practice, Chapter 4, these four tasks are: to *understand* relevant information appropriately presented, *retain* it for long enough to *use and weigh* it to reach a decision, then to *communicate* by any means possible that decision)The fourth step, inability to communicate, specifically refers to someone who cannot communicate in any way whatever, such as a person in a coma or with locked-in syndrome (see Section 4.15 of the MCA code of practice⁵⁸).

When considering a person who is self-neglecting, it can sometimes appear that a series of small decisions, each taken with capacity, could incrementally lead to a situation that was not chosen but which the individual did not have the capacity to understand and change. The distinction in the literature between decisional and executive capacity is seldom found in practice and its importance for determining responses to self-neglect needs to be considered further and be more fully understood in practice.

The emotional components of capacity are hard to identify, but may prevent the person from using and weighing information through, for example, fear of 'the state' or shame at not coping.⁵⁹

Checklist for mental capacity assessors

- The assessor is satisfied that the first part of the two-stage test, the diagnostic stage, is met.
- The assessor is clear about the concrete details of the choice facing the person, for example, between living in a care home and living at home with a realistic package of care (rather than just 'going home' with no clear outline of available support).

- The assessor is clear that the person has been given enough information about their options, expressed appropriately, and at their best time of day, to empower them to make this decision if at all possible (while not expecting them to necessarily retain peripheral and minor details).
- The person has been given all practical support as stated in the second principle of the Act.
- The assessor has taken into account any relevant factors relating to the person's diagnosis – for example, that a person with a brain injury may have a good theoretical understanding of the choice before him or her, while having great difficulty using and weighing information.
- Bearing in mind a person's right to make unwise decisions with capacity, the assessor has taken care to avoid inadvertently attaching excessive weight to their own views of how this person's physical safety may be best protected, and insufficient weight to the person's own views of how their emotional needs may best be met.
- The assessor is satisfied about which of the first three functions (understand, retain, use and weigh) the person is unable, on the balance of probabilities, to carry out, or whether the person is unable in any way to communicate a decision.
- The recording is clear and is there evidence to bear out the assessor's assertions.

For an example of an audit tool to scrutinise DoLS assessments of mental capacity, see Appendix 3.

No Refusals assessment (standard form 3)

What makes a good no refusals assessor

This assessment must be carried out by a best interests assessor, who must be clear about the legal standing, and authority, of lasting powers of attorney, court-appointed deputies and Advance Decisions to Refuse Treatment. These matters are covered in the MCA code of practice,⁶⁰ Chapters 7, 8 and 9. A best interests assessor who finds that there is a lasting power of attorney in place, if there is no relevant refusal, must be aware that, if the relevant person lacks capacity to choose their own representative, the attorney may select the relevant person's representative and may if they wish select themselves.

What makes a good no refusals assessment

The relevant person meets the no refusals requirement unless there is a refusal within the meaning of Schedule A1 to the Mental Capacity Act 2005⁶¹ paragraph 19 or 20:

19(1) There is a refusal if these conditions are met:

- (a) the relevant person has made an advance decision
- (b) the advance decision is valid

(c) the advance decision is applicable to some or all of the relevant treatment.

20(1) There is a refusal if it would be in conflict with a valid decision of a donee or deputy for the relevant person to be accommodated in the relevant hospital or care home for the purpose of receiving some or all of the relevant care or treatment:

- (a) in circumstances which amount to deprivation of the person's liberty, or
- (b) at all.

Example from practice

Josef's niece, Clara, has lasting power of attorney for health and welfare; Josef has lost capacity to consent to treatment. Josef is diagnosed as needing surgery on his foot, and the local hospital has applied for a standard authorisation in order to keep him in hospital against his will in order to operate on him. Clara informs the best interests assessor, who is carrying out the no refusals assessment, that Josef always chose to attend a specific different hospital, run by a religious organisation, for any surgical procedures: he recognises this hospital as a safe place and has been happy and compliant with treatment there since losing capacity. Clara therefore refuses her permission for him to be admitted to the local hospital, and requests Josef's doctor to arrange a consultation with Josef's preferred hospital.

Eligibility assessment (standard form 4)

What makes a good eligibility assessor

The assessor must be either a doctor with specific psychiatric expertise, often approved under Section 12 of the Mental Health Act, who has undergone appropriate training to be a medical assessor, or an AMHP who is also a best interests assessor. Either of them must if relevant have completed annual refresher training that satisfies the supervisory body as fulfilling this requirement.

What makes a good eligibility assessment

The assessor must be clear about what makes a person ineligible for the Safeguards (see the next section for problems that may arise in psychiatric hospitals). This is detailed in Schedule 1A⁶² to the Mental Capacity Act 2005 and the rule is spelled out, helpfully, in the eligibility form (form 9).

The Safeguards cannot be used as the mechanism for protecting the rights of a person if:

- the person objects to being in this hospital in order to be given treatment for their mental disorder or to be given some or all of the mental health treatment **and**
- no donee (person given rights under a Lasting Power of Attorney) or deputy appointed by the Court of Protection has made a valid decision to consent to each matter to which the person objects **and**

- the person meets the criteria for being detained under Sections 2 or 3 of the Mental Health Act.

It will sometimes happen that a person is referred for authorisation under the Safeguards, for example, in a community hospital or care home, but before the assessors can get there, the person's psychiatrist has admitted them to a psychiatric hospital under the Mental Health Act. This will be because, as above, the person requires treatment in a hospital, for a mental disorder, and is objecting to some or all of this. The MCA however cautions⁶³ that it cannot replace the Mental Health Act, or be seen as an optional 'less restrictive option' to the Mental Health Act. It is spelled out that nothing in the MCA authorises anyone:

(a) to give a patient **medical treatment for mental disorder**, or

(b) to consent to a patient's being given medical treatment for mental disorder if, at the time when it proposed to treat the patient, **his treatment is regulated by Part 4 of the Mental Health Act**.

The relationship between the MHA and the MCA relating to **treatment of a detained patient for a mental disorder** is that, generally, the MHA is the preferred legal mechanism to protect the human rights of the person:

An Advance Decision to Refuse Treatment relating to a mental disorder, or a decision by a health and welfare attorney refusing **treatment of a mental disorder**, can be overridden by use of the Mental Health Act 1983.

An exception relates to ECT (Electro-Convulsive Therapy), in that an advance refusal of **ECT**, or refusal of its use by a Lasting Power of Attorney donee, cannot be overridden except in specified emergency situations:

s62(a) MHA: immediately necessary to prevent death

s62(b) MHA: immediately necessary to prevent deterioration⁶⁴

A valid and applicable advance decision to refuse treatment, or a decision made by a health and welfare attorney acting within their powers (provided the decision is in the person's best interests) re **physical treatment** must be respected.

Eligibility assessments in psychiatric hospitals

Particular problems can arise in mental health settings if a deprivation of liberty has been identified and there is disagreement on the appropriate legal mechanism to use to protect the relevant person's rights under the European Convention on Human Rights.⁶⁵

Considering whether to use the Mental Health Act is the most appropriate first step in almost all circumstances, as the relevant person will have been admitted for assessment and treatment of a mental disorder.

However, if a person is no longer a mental health patient (because, for example, minimal improvement to their condition brought about by medicating them against their will is no longer proportionate), but needs to stay in hospital to be given medication for a physical disorder and lacks the capacity to be safely in charge of their own medication, that person may be deprived of their liberty because staff will not let them leave in their own best interests. In such a case the Safeguards are the appropriate route to protect the relevant person's rights.

The supervisory body and local mental health trusts (together with the CCG MCA lead) are advised to establish a protocol to address situations when a deprivation of liberty has been identified and the person has been assessed as ineligible for both the Safeguards and the formal powers of the MHA. Such situations typically occur when different groups of assessors have assessed the person separately. Where a deprivation of liberty is found, it is important that, if there is any doubt about the correct route to protect the person's rights, the responsible professionals discuss which is the appropriate framework to achieve this protection. MCA and MHA leads from the relevant trust or the local authority are often able to be consulted or involved in such discussions.

Checklist for eligibility assessors

- If the eligibility assessor is not the best interests assessor, that person's views have been sought.
- The eligibility assessor is clear what is the **purpose** of this hospital admission (treatment for a mental disorder or treatment for a physical disorder) in order to determine whether or not the person is eligible for DoLS.
- If the eligibility assessor needs further information to decide if the person is eligible for the Safeguards, they are aware of where to find it (the supervisory body or best interests assessor may hold such information).

Example from practice

Mr T is a 64-year-old with a diagnosis of alcohol-related dementia leading to hallucinations, paranoia, continued drinking, self-neglect, exploitation, assaults in the community and outbursts of violence and aggression.

He had briefly been detained under Section 2 of the MHA 1983, but his dementia did not respond to treatment. He remained on the ward since there was nowhere else for him to go, and his considerable physical health problems meant that he needed help with medication.

Mr T kept trying to escape from the ward and join his unit as he thought that he was still in the armed forces. Following a best interests meeting it was decided to seek a specialist care home placement. In the interim, it was identified that Mr T's rights needed protecting, and a request was made for a DoLS authorisation. The eligibility assessor examined carefully the nature of his treatment, and decided that, but for his physical condition and the need to manage this, combined with the difficulty of finding a suitable care home, Mr T would not have needed to remain in the mental health unit. Therefore he was not a mental health patient, and 'not ineligible' for DoLS.

Mr T remained on the ward, with the protection of an authorisation, until he was placed in a small specialist unit. During his time on the ward, his paid relevant person's representative, supported by an IMCA, requested that the supervisory body review the eligibility requirement, since they felt Mr T should have been detained again under the MHA. A different eligibility assessor came to the same conclusions as the first, that the DoLS authorisation was the appropriate legal framework to protect Mr T's rights.

Best interests assessment (standard form 3)

What makes a good best interests assessor

Eligibility to be a best interests assessor is described in the DoLS Regulations.⁶⁶

Best interests assessors are the lynchpin on which the entire edifice of DoLS rests, and they have a range of duties that fall to them within the operation of the Safeguards.

Best interests assessors are often the main assessors though a mental health assessor may also assess capacity. They are responsible for ascertaining that the person is 18 or older (the age assessment, now generally incorporated as part of the best interests assessment). They are solely responsible for assessing whether there are any lawful decision-makers who object to what is proposed (the 'no refusals' assessment). If qualified also as Approved Mental Health Professionals under the Mental Health Act 1983 (as amended), they are able to carry out the eligibility assessment, to decide whether this person's rights should be protected by the use of the MHA or the MCA, via the Safeguards.

Most significantly, they must carry out two vital tasks: they are responsible for deciding whether a restrictive situation is authorised by Sections 5 and 6 of the MCA, or whether it amounts to a deprivation of the person's liberty. If they conclude, given all evidence and scrutiny of the concrete situation of the person, and in the light of current case law, that the person is deprived of their liberty, they must assess holistically whether the restrictions are in the person's best interests, and proportionate to the risk and seriousness of harm to that person without the proposed restrictions. They must keep abreast of developments in case law to carry out these tasks correctly.

It is the role of the best interests assessor to:

- suggest any conditions that might reduce the need for ongoing deprivation of liberty, or lessen the impact of the deprivation on the relevant person
- frame any conditions so that they apply to such matters that the managing authority can control (rather than general care planning)
- discuss any conditions in advance of setting them with the managing authority, to ensure that the managing authority can comply
- suggest a maximum length for which authorisation can be granted – this can be for up to a year, although many supervisory bodies are reluctant to authorise for such a long period (however, an authoriser can shorten the period from that suggested by the best interests assessor, but cannot lengthen it).

Example from practice

Millie (39) has a learning disability, and following the death of her mother, who cared for her, has been placed in a care home as an emergency. The home has sought an authorisation under the Safeguards because Millie is distressed and resisting personal care in a very challenging way. The other residents are all older people with dementia. Both the best interests assessor and the IMCA, who was commissioned when the supervisory body found that Millie no longer had no close relatives or friends, feel the placement is wrong for her. The best interests assessor recommends authorisation for a maximum of four weeks to allow a best interests process to take place and somewhere more suitable to be found. She suggests a condition that the managing authority should recognise Millie's bereavement, and work with her to create a life story book.

If the person cannot choose their own representative, and there is no holder of a lasting power of attorney who can do this, it falls to the best interests assessor to suggest somebody. This is usually a fairly simple matter, and should be discussed when other matters are being explored as part of the assessment process. Where there are a number of children, for example, all aged over 18 and living quite locally, any of whom would be an ideal representative for their parent, best interests assessors often make a point of involving them (and the parent where possible) in the decision. Given the time-limited nature of the authorisation, some best interests assessors suggest that the adult children agree to take it in turns to carry out the representative role. The supervisory body administrators need to be careful in such a circumstance to comply with the regulatory framework and terminate one appointment before appointing another person, which must always be with the agreement of the person proposed (standard forms 25, 26 and 27).

The best interests assessor must come to an opinion on this wide range of matters, and provide sufficient evidence to enable the authoriser to understand how they reached their conclusions and recommendations. The evidence must be detailed, and gained from:

- discussion of the restrictions, and possible less restrictive options that have tried or might be available, with the person and their relatives or friends if any (and in the light of a report commissioned by the supervisory body from an IMCA if they have nobody other than paid carers to be consulted)
- examination of care plans and discussion with paid staff caring for the relevant person
- discussion with the mental health assessor, including gaining their opinion on the possible effects on the person's mental health of the authorisation
- contact with the eligibility assessor to share relevant information.

Support

It is the duty of the supervisory body to support the continued learning and practice development of best interests assessors. This is currently done in a range of ways. As well as the mandatory annual refresher training, many supervisory bodies:

- arrange regular meetings of best interests assessors with the DoLS lead, to discuss practice and case law;
- send out regular bulletins to assessors with highlights from Court of Protection or European Court of Human Rights judgements;
- encourage best interests assessors to attend regional or national assessor forums;
- have an MCA DoLS panel to which best interests assessors submit a set number of anonymised assessments per year, which are used to feed back individually or to groups of assessors;
- encourage recognition of best interests assessors by managers and peers as MCA and human rights champions;
- ensure that the DoLS lead supports them by being available for discussion if needed.

Assessments in hospitals

The best interests assessor's role is not to authorise or scrutinise clinical decision-making in any way. It is to look at the conditions surrounding the provision of care or treatment and decide whether or not those conditions deprive the relevant person of their rights to liberty and security of under Article 5 of the Human Rights Act 1998.

Most supervisory bodies have experienced little or no difficulty in identifying competent best interests assessors to carry out assessments in hospitals, even where all the best interests assessors are local authority staff. Many best interests assessors from the four qualifying professions (social work, occupational therapy, nursing and psychology) have experience in hospital settings, often across a range of specialist health provisions.

However, although the task is essentially the same and similar issues will arise, some local authority best interests assessors may be carrying out assessments in hospitals for the first time. As with care homes, the assessor will need to understand the environment in which the assessment is taking place.

The best interests assessor must recognise that there is a wide spectrum of different hospitals which might apply for an authorisation, ranging from small community hospitals often used for rehabilitation, to large acute hospitals with many specialities, to mental health units designed for compulsory detention. The nature of the specific hospital is relevant to a finding of deprivation of liberty, which is probably more likely within a setting where people are customarily detained than in a smaller more homely one.

The assessor should understand the legal context of hospital treatment and case law relevant to hospital settings. A best interests assessor should also be able to recognise when it may be appropriate for the hospital to make an application to the Court of Protection under Practice Direction 9e⁶⁷ (applications relating to serious medical treatment) ref to PD9e.

Example from practice

Molly (91) was admitted to a large general hospital from her home with a chest infection. She had advanced dementia, and her daughter Jean had given up her work as a hospital nurse to care for her, with the help of two other nurses funded by a direct payment. The family belonged to a minority religious group, and often felt misunderstood by the wider community.

Molly lacked capacity to consent to admission, or to treatment: her admission, and the treatment for her chest infection, were agreed to be in her best interests. Molly also had a pressure sore and an infected toe. Jean and the other nurses had been treating these under the supervision of the GP, who agreed that Molly was probably approaching the end of her life.

Relations between ward staff and Jean were poor. Jean was seen as bossy and interfering, and in her turn she felt staff ignored her greater knowledge of her mother's condition. She also complained about staff being slow to provide essential personal care. Voices were raised on both sides. Staff then criticised Jean's previous care of her mother, citing the pressure sore, and raised a safeguarding alert. They allowed other relatives, and religious leaders, to visit Molly, but barred Jean from the ward. Jean's solicitor queried this and the hospital then gave itself an urgent DoLS authorisation, and requested a standard authorisation.

The best interests assessor, Frank, spoke to the other nurses who had looked after Molly at home, and to the GP. They praised Jean's nursing skills and commitment to her mother's wellbeing, while commenting on her perfectionism and tendency to micro-manage. Molly's elderly husband, and other relatives and friends, all wanted Molly home as soon as she was well enough, to be cared for by Jean, the other nurses and the GP, for the rest of her life. The hospital's position was that Molly should remain there, so her other medical problems could be treated. Staff said that if the deprivation of liberty was not authorised they would still prevent Jean from seeing her mother, under the umbrella of safeguarding. Frank explained that where relatives and professionals disagreed, if mediation was unsuccessful the hospital must apply to the Court of Protection for a best interests decision. He shared his opinion that it was disproportionate to the risk and seriousness of harm to Molly to refuse to allow Jean to visit, and to refuse to consider whether, and how, Molly might return home.

After discussions with the hospital's legal department, and with the GP, it was decided that Molly's treatment could safely continue in her own home, with additional input from the district nurses.

What makes a good best interests assessment

The key questions for a best interests assessment is what the person wishes for and where they want to be. Lord Justice Munby, lecturing in different parts of the country to Safeguards Adults leads from local authorities and health settings,⁶⁸ has often stressed that, fundamental to the process of properly engaging the person in the decision-making process, is listening to and taking account of their wishes and feelings. The fact that people lack the relevant capacity does not mean that their wishes and feelings simply fall out of account. It is elementary that decisions are made by reference to the

vulnerable adult's best interests. It is equally elementary that in determining where the best interests of these people truly lie it is necessary to have regard to their wishes and feelings, whether verbalised or articulated or not. To have regard to their wishes and feelings is not merely something mandated by the European Convention on Human Rights and the Mental Capacity Act. It is surely fundamental to treating P as a human being and with dignity.

The second key question is assessing whether any restriction or restraint is covered under Sections 5 and 6 of the MCA or whether it goes beyond this and amounts to a deprivation of liberty. This entails a good understanding of case law, both from the UK courts and from the European Court of Human Rights.

These two tasks require best interests assessors to follow the best interests checklist in Section 4 of the MCA. This includes interviewing the person and their relatives if any (or, if they have no relatives or friends apart from paid staff, taking account of the IMCA's views and findings) and also considering whether the proposed restrictions are proportionate **both** to the likelihood of harm to the person and to the seriousness of that harm.

Authorisers

What makes a good authoriser

Who can be an authorising signatory is not defined within Schedule A1⁶⁹ to the Mental Capacity Act 2005 or the Regulations. However, while the limitations of the role are laid down in Schedule A1, case law has amplified and illuminated its importance. The authoriser represents the local authority, and it is a role of great responsibility. The authoriser must not be in a position of conflict (for example, they must not manage the managing authority in addition to the DoLS service).

Example from practice

One local authority has a policy that authorisers must be of sufficient seniority that they would authorise guardianship under the Mental Health Act 1983 or deputyship (Court of Protection). Their authorisers are appointed in writing by a minute of a senior governance committee. Newly-appointed authorisers are invited to shadow more experienced colleagues.

Similarly, local authorities should be aware of, and pre-empt, any conflicts of interest within their authorising roles – for example, if they, as managers who may authorise care packages, also line-manage a best interests assessor who may be asked to assess an individual who is in receipt of such a care package.

Limitations of the authoriser's role

- A supervisory body **must** give a standard authorisation if all assessments support this and it has them in writing (with provisos) (Schedule A1 50(1) (a) and (b)).
- A supervisory body **can** shorten the time suggested by the best interests assessor but not lengthen it (Schedule A1 51 (1) (1) and (2)).
- A supervisory body **must** consider any conditions suggested by the best interests assessor: the authoriser **may** also add or remove conditions (Schedule A1 53 (1) (2)). Note that it is good practice that they consult with the best interests assessor if considering adding or removing conditions, and that the best interests assessor is allowed to request that they be informed if the authoriser removes or changes any conditions they have suggested, and if they have concerns that such a change might affect their conclusions.
- Any conditions that are set **must** relate solely to the deprivation of liberty and must relate to the managing authority. The managing authority **must** be able to comply with them (Schedule A1 53(3)).

If an assessor asserts that an ongoing situation does deprive a person of liberty but is not in their best interests, and there is no identified alternative place for the person where they would be safe, an authoriser should be alerted to the evident risks to the person's safety if the authorisation is not granted. If this situation arises, the authoriser

should discuss with the assessor the possibility of authorising deprivation of liberty for a short period, while arrangements are made for a less restrictive alternative.

Example from practice

Mrs M, who has dementia, was moved from her home to a care home as an emergency following the sudden death of her husband, who had cared for her. Since she was continuously asking to go home, and unable to comprehend her husband's death, the care home gave itself an urgent authorisation, and applied for a standard one.

When the best interests assessor visited, he found that there was a deprivation of liberty, and that it was in Mrs M's best interests to remain in the home in the short term while other options were explored: the authorisation was granted for four weeks. When this authorisation was about to expire, the assessor re-visited, and was very concerned to find that Mrs M had not settled, and had lost a considerable amount of weight. He discussed with the authoriser and with the care home manager his view that the ongoing deprivation of liberty was evidently not in Mrs M's best interests since she was so unhappy, although no less restrictive options for her care had been identified.

The care home manager rang the authoriser to say she would have no authority to keep Mrs M safely at the home over the weekend if the authorisation was not granted. She felt it was impossibly risky to let Mrs M, who was extremely confused, return home to an empty house: she had found that Mrs M's daughter was away for the weekend, and unable to return home immediately to care for her mother. The authoriser consulted with the assessor and the relevant service manager, who agreed to arrange a best interests meeting (to include Mrs M and her daughter) for the following week to explore how best to ascertain and meet Mrs M's best interests. The assessor recommended a maximum length for a subsequent authorisation of a further three weeks, and the authoriser agreed.

Scrutiny of assessments

A supervisory body would be 'essentially passive' if it accepted poor assessments: if not satisfied, the person in the role of authoriser could either ask the best interests assessor to re-visit, or request a review of the authorisation, or apply to court.

Decisions to be made, and documents scrutinised, by the authoriser

It is a matter for local decision whether an authoriser is used to ratify an 'authorisation not granted' (form 13) or not, though increasingly supervisory bodies are asking them to do so:

- in order that the authoriser can understand the reasons for the decision
- as a protection for the supervisory body since this form is described as signed on behalf of that body.

If the granting of an authorisation is recommended, authoriser will **always** be asked to sign form 12, 'authorisation granted': by doing this they create the authorisation. All the assessments are summarised or copied into this form.

Authorisers may wish to see the originals, and if so they should be easily available to them (i.e. part of the bundle of material substantiating the authorisation). If hand-written, they must be legible.

Care plans should be appended: there should be evidence of the managing authority trying to minimise restrictions, awareness of the human rights of the person, and of the principles of the MCA.

Assessors as independent professionals are responsible for their decisions, but there must be sufficient evidence for the authoriser to understand how they have reached those decisions. Authorisers must be able to gain as full a picture as possible of the assessment process, on the basis of which they are confident to authorise the deprivation of this person's liberty. If any of the assessments fail to give evidence for the decisions made, or if it is clear that the correct process has not been carried out (for example, close relatives were available for consultation but were not approached by the best interests assessor), it is the authoriser's responsibility to request further evidence to substantiate the decisions reached.

An authorisation for signature may contain conditions, often suggested by the best interests assessor, which are intended to reduce the restraint so that the person is no longer deprived of their liberty or to lessen the impact of the deprivation.

The conditions must relate to the issues that mean a person is deprived of liberty, rather than general matters of care management. Conditions are binding upon the managing authority, and should be matters they can achieve. Aspects of care management can, if relevant, be discussed with appropriate service managers who are outside the DoLS process, but a DoLS authorisation, or its conditions, cannot be used to enforce care management or commissioning actions.

The authoriser can add further conditions, or remove conditions suggested by the assessor. A best interests assessor can insist on being notified if conditions they have suggested are removed, since this may in certain circumstances alter their opinion about whether the authorisation remains in the person's best interests. It is general good practice for this consultation to take place.

Example from practice

Jehan has a learning disability and physical disabilities that make it hard for him to communicate. Staff have learned, from Jehan's parents, that when he is stressed it calms him to play with balloons: his sign that he wants to do this is that he blows out little puffs of breath. Jehan's care plan explains to staff that they should blow up balloons for him when he does this, and that they should also explore what might have caused him to feel stressed. The aim of this is to enable them to reduce incidents when they have to restrain him in his best interests. The best interests assessor finds inconsistency in staff awareness of this. She suggests a condition that the managing authority monitors staff training about Jehan's care plan, and records adherence to it. She adds the requirement that, if the authoriser removes this condition, she wants to be informed since she does not think the authorisation could be said to represent the least restrictive option and be in Jehan's best interests, without this condition to ensure his care plan is complied with.

Checklist for authorisers

The 'authorisation granted' (form 5)

The authoriser's role is to scrutinise the authorisation, to look for a convincing narrative, giving a clear picture of the person and 'how we got to where we are'. It is not their role to overrule the findings of an assessor acting within their prescribed role who has provided evidence to justify their opinion: but the authoriser may, and should, require further evidence if that provided appears too scanty to justify action in such a serious matter as depriving fellow citizens of their liberty.

Form 12 must detail evidence of:

- the person's past and present views and wishes
- the views of their relatives/friends or the opinion of an IMCA
- the restrictions being both necessary and proportionate
- less restrictive options having been tried/explored
- why less restrictive restrictions are not enough
- the case being made that the authorisation is proportionate to the likelihood of harm to the person and the seriousness of that harm.

Conditions relating to an authorisation

The authoriser can add or remove conditions, which must relate to reducing deprivation of liberty, not simply to better care planning. Conditions are binding on the managing authority, so must be achievable by them (rather than by others such as the commissioning authorities).

- If there are conditions, do they reduce the likelihood of the person being deprived of their liberty?
- Can the authoriser identify further conditions that might reduce deprivation of liberty?

Length of authorisation

- An authoriser can shorten an authorisation but not lengthen it.
- In such cases authorisers must clear why the period is to be shortened and what they hope to achieve by this.

Conclusion

The authoriser must be satisfied that there is enough evidence that this deprivation of liberty is in the person's best interests, and that the removal of liberty is both warranted and **proportionate**. The authoriser should be alert to indicators of possible poor practice in case planning or practice, and should have sufficient seniority to raise these where appropriate through operational governance frameworks, including those in hospitals or CCGs.

Useful links

[Court of Protection](#)

[Court of Protection case reports](#)

[Court of Protection newsletters](#)

[Care Quality Commission \(CQC\)](#)

[CQC DoLS report 2014/15](#)

[CQC – MCA DoLS guidance for providers](#)

[CQC – MCA guidance for providers](#)

[Death of a person subject to an MCA DoLS authorisation](#)

[Department of Health \(DH\)](#)

[DH MCA archived pages](#)

Some of the historical information regarding the MCA and DoLS has been placed in an archive by the Department of Health but the pages remain relevant.

[European Convention on Human Rights](#)

[European Court of Human Rights](#)

[NHS Digital](#)

[Human Rights Act 1998](#)

[IMCA Service – 7th Annual Report](#)

[Lasting Power of Attorney](#)

[Lucy Series, Mental Capacity Act and DoLS blog](#)

[UK General Public General Acts from 2005](#)

[MCA 2005](#)

[MCA Code of practice](#)

[Office of the Public Guardian](#)

[Mental Capacity Act: making decisions](#)

MCA/Deprivation of Liberty Safeguards, Schedule A1, and associated regulations

MCA Deprivation of Liberty Safeguards

MCA DoLS standard forms (alternatively forms can be obtained from local authority DoLS offices)

Mental Capacity Act 2005, Deprivation of Liberty Safeguards (England), Annual Report 2015–16

Mental Capacity Law and Policy blog

Mental Capacity Act (MCA) Directory

The MCA Directory helps to raise awareness about the MCA, including the [Deprivation of Liberty Safeguards](#). You will find useful information and various tools to help understand or implement it. There is material here for people who may be subject to the Act's provisions, and for professionals from a range of backgrounds.

Mental Health Act 2007

Mental Health Act 1983 Code of Practice

Mental Health Foundation MCA literature review

Mental Health Law Online

Ministry of Justice

National Institute for Health and Care Excellence (NICE) quality standard and guidance for patient experience in adult NHS services

NICE quality standard for service user experience in adult mental health

Neary judgement

This is of crucial importance to the workings of a supervisory body.

NHS Commissioning Board: 'Commissioning for quality and innovation' guidance

Patient Experience Framework

This has been agreed by the National Quality Board and describes the aspects of a health care experience which people who use services have said matter most to them. Clearly different people in different settings will have different priorities for what is important within this framework.

Post Legislative Assessment – Mental Health Act 2007 (also covers the amendments to Mental Capacity Act to include DoLS)

Social Care Institute for Excellence – MCA and DoLS resources

Supreme Court judgement in the cases of P v Cheshire West and Chester City Council and P and Q v Surrey County Council

Transforming Patient Experience

A guide published in February 2013 by the NHS Institute

UK Human Rights blog

Universal Declaration of Human Rights (UDHR)

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Deprivation of Liberty Safeguards: putting them into practice

This resource describes good practice in the management and implementation of the Deprivation of Liberty Safeguards (DoLS; the Safeguards). It includes the roles of clinical commissioning groups (CCGs) and wider local authority governance.

The resource is structured with freestanding sections on hospitals, care homes, supervisory bodies, assessors and authorisers, hence there is some inevitable repetition between them.

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