

ARTICLE

Interface between the Mental Health Act and Mental Capacity Act: deprivation of liberty safeguards[†]

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SUMMARY

The deprivation of liberty safeguards were introduced into the Mental Capacity Act in 2008 to enhance the protection of adults in residential homes or hospitals who lack capacity in relation to their care arrangements and who are or may be deprived of their liberty. Deprivation of liberty itself is an imprecise concept and there may be difficulty in applying the appropriate authority where there is a choice between the Mental Capacity Act 2005 and the Mental Health Act 1983. Therefore, this article explains the evolution of mental capacity legislation and the concept of deprivation of liberty, how it may be recognised, prevented and authorised by deprivation of liberty safeguards, along with some of the interface issues with the Mental Health Act 1983.

DECLARATION OF INTEREST

None.

[†] For a commentary on this article see pp. 438–439, this issue.

In April 2008, the deprivation of liberty safeguards were introduced into the Mental Capacity Act 2005 for England and Wales. They represent a long-awaited legislative response to the *HL v. United Kingdom* [2004] judgment (the Bournemouth judgment) by the European Court of Human Rights. The court held that HL had been deprived of his liberty within the meaning of Article 5(1) of the European Convention on Human Rights and that the deprivation of liberty had not been ‘in accordance with a procedure prescribed by law’ (Box 1). Before *HL* there had been long-standing concerns over the status of incapacitated persons who were informally admitted to hospital but in effect detained. The judgment in *HL* represented a significant breakthrough in the protection of vulnerable individuals detained informally within institutions. The concept of deprivation of liberty, however, remains ambiguous and the safeguards do not provide clear guidance on the circumstances in which it occurs. Therefore, there will be difficulties in translating this imprecise legal principle into routine clinical practice.

The safeguards are intended to provide the statutory framework for authorising deprivation of

liberty in particular situations: where an individual lacks the capacity to consent to care or treatment and the circumstances of their care within the care home or hospital amount to deprivation of liberty. It follows that there are now different legislative routes that may apply to patients who lack capacity and may also require detention to provide care or treatment. The routes follow the provisions of the amended Mental Health Act 1983 and Mental Capacity Act 2005. The principles, provisions, purposes and policy concerns of the two Acts are quite distinct but there will be instances where the most appropriate choice of legal authority is unclear and the interrelationship between the Acts will be complicated. This article will therefore discuss the historical development of the Mental Capacity Act; how the concept of deprivation of liberty has emerged from domestic and European case law and, so far as it is currently possible, how it may be recognised, prevented and authorised. Finally, in situations where there is a potential for individuals to be deprived of their liberty there will be instances where there is a choice of mechanism of detention between the Mental Capacity Act (deprivation of liberty safeguards) and the Mental Health Act. We will therefore discuss aspects of the interface between the two Acts to determine the most appropriate choice of detaining mechanism.

The evolution of incapacity legislation

The Mental Health Act and the emergence of common law

A brief consideration of how incapacity legislation has evolved is helpful to conceptualise why the current legal situation has emerged. The Mental Capacity Act 2005 and the processes of personal decision-making for individuals lacking capacity can be traced to De Prerogativa Regis of 1324, but a significant milestone was the Mental Health Act 1959. This established the Court of Protection and allowed for the appointment of a receiver to manage property and affairs. Notably, there were complex and extensive provisions for guardianship under the 1959 Act that allowed the guardian to

make personal welfare decisions. This was done infrequently and the 1983 Mental Health Act subsequently attenuated the authority of the guardian. The loss of guardianship powers relating to property and personal welfare decisions created a legal lacuna. The courts were then required to deal with cases and common law evolved to fill the gap. Particular issues that the courts had to contend with were how capacity was to be defined, what legal jurisdiction existed to make decisions on behalf of persons lacking capacity, who could exercise it and how best interests were determined.

The Mental Capacity Act

The Mental Capacity Act is remarkably similar to the proposals made by the Law Commission (1995) following a general consultation in relation to mentally incapacitated adults and decision-making. The Act codified common law and provides a statutory framework in England and Wales in relation to the decisions made for those who lack capacity to make their own. The *Mental Capacity Act 2005 Code of Practice* (Department for Constitutional Affairs 2007) contains a comprehensive discussion and guidance on the provisions of the Mental Capacity Act. The scope of the Act is extremely wide and potentially affects the whole population over the age of 16.

The provisions of the Mental Capacity Act include: how one defines incapacity; how capacity should be assessed; and who can take decisions in which situations and how they should go about this. It also enables people to plan ahead for a time when they may lose capacity. Decisions may be simple or wide-ranging and include those relating to treatment for physical or mental disorder. The Act created a new statutory service – the Independent Mental Capacity Advocate (IMCA) service.

Underpinning the Act are five statutory principles (Box 2). Generally, these flow from common law and reflect the importance of protecting the autonomy of the incapable individual and make it clear that a person should be assumed to have capacity unless proven otherwise. The definition of best interests represents a departure from common law and takes the form of a checklist. In making a determination of best interests a number of considerations must be taken into account, including: the likelihood and timing of recovery; encouraging the participation of the individual as far as possible; the decision to be made should not be motivated by a desire to bring about death; and the past and present wishes, beliefs and values should be considered along with the opinions of any named relative, carer or substitute decision-maker.

BOX 1 *HL v. United Kingdom [2004]: the judgment of the European Court of Human Rights*

The facts

- HL had severe autism with limited powers of communication
- He had complex needs and at times demonstrated challenging, disruptive behaviour
- Aged 45, after many years of institutional care, he moved to live in the family home of Mr and Mrs E
- In July 1997, while attending a local authority day centre, he became distressed and agitated
- He was subsequently admitted as an informal patient to Bournemouth Hospital
- Contact between him and his carers was initially proscribed to prevent HL becoming more agitated
- He was sedated in hospital and kept under continuous nursing observation
- He was compliant and made no attempts to leave
- It was decided that he would be stopped from leaving should he make any attempt to do so

- Mr and Mrs E, and his care coordinator, did not believe that he needed to be in hospital
- In considering the issue of lawful detention, HL eventually lost in the House of Lords
- The European Court of Human Rights was concerned with deprivation of liberty under Article 5 and handed down judgment in October 2004

Judgment of the European Court of Human Rights

- HL had been deprived of his liberty
- Healthcare professionals had exercised complete and effective control over his care and movements
- He had no recourse to the protections offered by the Mental Health Act 1983 and the absence of procedural safeguards and access to the court amounted to a breach of Article 5(1) and (4)
- ‘the applicant was under continuous supervision and control and was not free to leave’

Thus, the Mental Capacity Act makes provision for individuals who, because of long-standing or temporary incapacity, require a degree of or complete authority over personal welfare decisions. The Act, however, as formerly introduced did not authorise the detention of these individuals

BOX 2 *The five principles underpinning the Mental Capacity Act 2005*

- A person must be assumed to have capacity unless it is established that he lacks capacity
- A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success
- A person is not to be treated as unable to make a decision merely because he makes an unwise decision
- An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests
- Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action

(Mental Capacity Act 2005: Part 1 (1))

where detention under the Mental Health Act is inappropriate. Therefore, in response to *HL v. United Kingdom* [2004] the structure that was ultimately introduced in Schedules A1 and 1A of the 2005 Act are the deprivation of liberty safeguards discussed below.

Development of the concept of deprivation of liberty

A full discussion of the relevant case law is beyond the scope of this review. However, it is noteworthy that the statement of principle dates back to the judgment in *Guzzardi v. Italy* [1980]. In this case a suspected Mafioso had been the subject of a compulsory residence order instructing him to live on a small island called Asinara. The European Court held that he was deprived of his liberty within the meaning of Article 5(1) and that to determine whether this was the case, ‘the starting point must be the concrete situation and account must be taken of a whole range of criteria such as the type, duration, effects and manner of implementation of the measure’. The Court added: ‘The difference between deprivation of and restriction upon liberty is merely one of degree or intensity, and not one of nature or substance.’

The Mental Capacity Act 2005 Code of Practice

In consideration of the circumstances that may amount to deprivation of liberty and the range of factors that must be taken into account it is helpful to bring together a number of different strands from relevant codes of practice and domestic case law. Deprivation of liberty (which is not allowed without formal authorisation) and ‘restriction of liberty’ (which may be authorised by the Mental Capacity Act) are considered briefly in the *Mental Capacity Act 2005 Code of Practice* (Department for Constitutional Affairs 2007: Chapter 6). This chapter discusses Sections 5 and 6 of the Mental Capacity Act.

Mental Capacity Act, Section 5

Section 5 offers protection for carers and staff from liability for acts undertaken in connection with care or treatment. Protection from liability is, however, only afforded if they reasonably believe that the person lacks capacity in relation to the matter in question, the action is in the individual’s best interests and the Act’s statutory principles are followed.

Mental Capacity Act, Section 6

Section 6 authorises the use of restraint and sets out the limitations of its use.

Deciding whether there has been a deprivation of liberty

The *Code* acknowledges the difficulties in differentiating between actions that amount to a restriction of liberty and those that result in a deprivation of liberty, but in certain circumstances there may be no alternative way to provide care and treatment. The *Code* (p. 109) reiterates the statement of principle in the following way:

There must therefore be particular factors in the specific situation of the person concerned which provide the ‘degree’ or ‘intensity’ to result in a deprivation of liberty. In practice, this can relate to:

- the type of care being provided
- how long the situation lasts
- its effects, or
- the way a particular situation came about.

In Justice Munby’s judgment in *JE v. DE and Surrey County Council* [2006] (Box 3) three elements were identified that are relevant in considering whether, in the case of an adult, there has been deprivation of liberty:

- 1 An objective element of a person’s confinement, namely what are the concrete facts in relation to the individual concerned? Thus, for DE the circumstances were that he was not free to leave the home in question but was under the ‘complete

BOX 3 The judgment in *JE v. DE and Surrey County Council* [2006]

- DE was 76, had experienced a stroke, was blind and was diagnosed as having vascular dementia
- He lacked capacity to make decisions about his residency but could express his wishes clearly
- JE and DE had a long-term relationship and married in June 2005
- DE had lived voluntarily at a home ‘X’ but was taken to live at JE’s home in August 2004
- JE placed him on a chair on the pavement outside her house in protest at her not receiving adequate support
- DE was returned to home X by Surrey County Council in September 2005 and then moved to home Y on 14 November 2005
- At both X and Y, DE was given a significant degree of freedom and his activities in and around the homes were not restricted
- He often expressed a wish to leave and live with JE but this was not allowed
- Surrey County Council maintained that it was not in DE’s best interests to live with JE
- JE claimed that the Council had breached DE’s Article 5 rights and the Article 8 rights of them both

and effective control' of Surrey County Council and therefore deprived of his liberty, despite the actions being motivated by his best interests.

- 2 A subjective element, namely has the person given valid consent to the particular circumstances in question? In the case of DE, Justice Munby was concerned with the expressed wishes of the particular individual in that all he wished to do was to return to live with his wife and not be involved with any other activities that were offered. Therefore, it is important to consider that expressed objections will be a strong indicator of deprivation of liberty, even in the absence of the relevant decision-making capacity.
- 3 The deprivation of liberty must be imputable to the State, that is, the State can be demonstrated to be responsible. For instance, the detention takes place in a hospital or care home that is run by a public authority. Even when the detention is in a privately owned establishment, the particular circumstances may mean that the State is directly involved in the detention.

Following on from this, the *Deprivation of Liberty Safeguards: Code of Practice* (Department of Health 2008: p. 17) lists factors that may be relevant in the identification of whether the circumstances of care involve more than just restriction and amount to deprivation of liberty:

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

Sedation

Sedation is worthy of more detailed consideration, given that it is a frequent medical intervention in both psychiatric and general hospital settings. The use of sedation in an emergency situation to manage an individual's disturbed behaviour would probably not in itself constitute a deprivation of their liberty. However, it may be, if: it is used to prevent a patient's persistent attempts at leaving a hospital or care home; it is used in a non-emergency

situation; or the purpose of the sedation is to protect people other than the individual concerned. In these situations where an individual with a mental disorder is objecting to care or treatment it is an indicator that may point to the use of the Mental Health Act rather than the Mental Capacity Act.

Reducing the risk of deprivation of liberty

Given the importance of a person-centred approach to care and of minimising the risk that deprivation of liberty will occur, the *Deprivation of Liberty Safeguards: Code of Practice* (Department of Health 2008: pp. 18–19) also considers the practical steps that can be taken to reduce that risk:

- Make sure that all decisions are taken (and reviewed) in a structured way, and reasons for decisions recorded.
- Follow established good practice for care planning.
- Make a proper assessment of whether the person lacks capacity to decide whether or not to accept the care or treatment proposed, in line with the principles of the Act [...].
- Before admitting a person to hospital or residential care in circumstances that may amount to a deprivation of liberty, consider whether the person's needs could be met in a less restrictive way. Any restrictions placed on the person while in hospital or in a care home must be kept to the minimum necessary, and should be in place for the shortest possible period.
- Take proper steps to help the relevant person retain contact with family, friends and carers. Where local advocacy services are available, their involvement should be encouraged to support the person and their family, friends and carers.
- Review the care plan on an ongoing basis. It may well be helpful to include an independent element, possibly via an advocacy service, in the review.

Interpreting the law for those in care

Despite all of these considerations there remains a fundamental difficulty in relation to people in hospitals or care homes in determining which of them are being deprived of their liberty. Until there is more guidance available from government or through judgments handed down through the courts there is likely to be a considerable amount of variation in how the law is interpreted. Notwithstanding this, the starting point in consideration of whether deprivation of liberty is occurring is the individual's care plan. For any individual, it will be helpful to summarise what elements of the care plan are likely to be judged against the factors above; consider the effects of the care arrangements on the person's individual freedoms along with their expressed intentions; and whether the cumulative effects of the restrictions imposed go beyond mere restriction. Regardless of the lack of clarity, it is vital that clinicians develop

their appreciation and familiarity of the concept so that an awareness of it becomes an integral part of their routine practice.

The deprivation of liberty safeguards

The deprivation of liberty safeguards introduced as part of the 2007 amendments to the Mental Health Act are complex, introducing new roles and procedures. The safeguards apply to people aged 18 and over who have a mental disorder or intellectual disability and lack decision-making capacity in relation to their residency in a hospital or care home and who are assessed as needing to be deprived of liberty. The deprivation of liberty must be in the individual's own best interests, as defined by the Mental Capacity Act 2005, to protect them from harm and to ensure that they receive the care and/or treatment that they need. The safeguards are not to be used solely to protect other people from harm and do not apply to people who receive the necessary Article 5 safeguards by virtue of being detained under the Mental Health Act 1983. Provisions for people deprived of liberty to challenge their deprivation in a court of law are also included.

Responsibility for authorisation

It is the 'managing authority' of a hospital or care home that has responsibility for applying for a standard authorisation of deprivation of liberty to the 'supervisory body'. In the case of a National Health Service hospital the managing authority is the body responsible for running the hospital and in the case of a care home or private hospital it will be the person registered under Part II of the Care Standards Act 2000. The supervisory body will be the commissioning primary care trust in the case of hospitals (in England) and where the managing authority is a care home it will be the local authority where the person is an ordinary resident. In Wales, deprivation of liberty can be authorised by Welsh Ministers or local health boards. The supervisory body is responsible for considering requests for standard authorisations, commissioning assessments and where all of the assessments agree, authorising deprivation of liberty.

The assessments and effect of deprivation of liberty

To establish whether or not the qualifying requirements of the deprivation of liberty safeguards are met and whether it is appropriate to issue a standard deprivation of liberty authorisation, the supervisory body is required to arrange for the following assessments to be undertaken:

- age assessment
- no refusals assessment
- mental capacity assessment
- mental health assessment
- eligibility assessment, and
- best interests assessment

(see Table 1 for description of the purpose and who may undertake the individual assessments). The assessments must be done by at least two people and will be recorded on standard forms. The regulations and the *Code of Practice* set out how conflicts of interests between the assessors, their employers and the individual under assessment are avoided. Where deprivation of liberty needs to be authorised in an emergency, the managing authority may itself issue an urgent authorisation pending completion of the standard authorisation application process. An urgent authorisation may initially be for a maximum of 7 days but may be extended by the supervisory body for up to a further 7 days in exceptional circumstances.

The regulations in England specify that the assessment process for a standard authorisation must be completed within 21 calendar days of the date on which the supervisory board receives a request or within the period for which an urgent authorisation has been granted. In Wales, the regulations specify that all assessments required for a standard authorisation must be completed within 21 days of the date the assessors were instructed by the supervisory body. If any of the qualifying requirements are not met, a deprivation of liberty authorisation cannot be given.

The best interests assessor

The best interests assessor plays a central role in the deprivation of liberty safeguards process comparable to that of the approved mental health practitioner in the Mental Health Act assessment process. A best interests assessor:

- is an approved mental health practitioner or a member of the professions eligible to be an approved mental health practitioner;
- has at least 2 years of post-registration experience;
- has successfully completed training that has been approved by the Secretary of State to be a best interests assessor; and
- has the skills necessary to obtain, evaluate and analyse complex evidence and differing views and to weigh them appropriately in decision-making.

The best interests assessor is required, by regulations, to supply relevant information to the medical practitioner carrying out the mental

health or eligibility assessment. They are required to evaluate the care plan, seek the views of those involved in caring for the individual, involve the person and support them in the decision-making process. They must state how long the authorisation should last (up to a maximum of a year) along with any necessary conditions and recommend someone to be appointed as the 'relevant person's representative'. Finally, they are required to submit a report to the supervisory body, within an agreed time frame, stating the reasons for their conclusions.

Psychiatrists may be called on to undertake any one or all of the mental health, mental capacity and eligibility assessments, assuming the supervisory body is satisfied that the assessor has the required skills, experience, qualifications and training (Table 1). Ideally, the supervisory body should consider using a doctor who is already known to the relevant person and should ensure that the assessor is suitable for the particular case. Registered medical practitioners undertaking mental health assessments need to establish whether the relevant person has a mental disorder

within the meaning of the Mental Health Act 1983. Given positive assessments individuals with intellectual disabilities can receive deprivation of liberty safeguards whether or not their disability is associated with abnormally aggressive or seriously irresponsible conduct. The mental health assessor is also required to assess how a person's mental health will be affected by the deprivation of liberty and inform the best interests assessor of these conclusions.

Deciding to apply the Mental Health Act or the Mental Incapacity Act

For an individual who lacks capacity and who requires care or treatment there may be a choice of provisions to which he or she may be subject. When someone is not deprived of their liberty, the preferred authority should be regulated by the provisions of the Mental Capacity Act. In general, where there is a requirement for detention and treatment for a physical disorder the Mental Capacity Act should prevail. There will, however, be individuals who lack capacity and require treatment for mental disorder and therefore may

TABLE 1 The requirements for a deprivation of liberty standard authorisation

Assessment	Purpose	Who can carry this out
Age	Is the relevant person over 18?	Anyone who the supervisory body is satisfied is eligible to be a best interests assessor (approved mental health practitioner or other suitably trained professional)
No refusals	Establish whether a deprivation of liberty authorisation would conflict with another existing decision-making authority, e.g. Is there a valid advance decision applicable to some or all of the treatment in question? Is there conflict with the valid decision of a donee or court-appointed deputy?	Anyone who the supervisory body is satisfied is eligible to be a best interests assessor (approved mental health practitioner or other suitably trained professional)
Mental capacity	Does the relevant person lack the appropriate decision-making capacity on whether they should be accommodated in the hospital or care home or receive the recommended treatment?	Registered medical practitioner approved under Section 12 of the Mental Health Act or with special experience in diagnosis or treatment of mental disorder. Must have completed appropriate training Or best interests assessor (approved mental health practitioner or other appropriately trained professional)
Mental health	Does the relevant person have a mental disorder within the meaning of the Mental Health Act 1983? How will the mental health of the person being assessed likely be affected by being deprived of their liberty? Must report their conclusions to the best interests assessor	Registered medical practitioner approved under Section 12 of the Mental Health Act or with special experience in diagnosis or treatment of mental disorder, e.g. general practitioner with special interest. Must have completed appropriate training
Eligibility	Need to consider whether the relevant person is not eligible for deprivation of liberty authorisation because: they are detained as a hospital in-patient under the Mental Health Act 1983 or the authorisation would be inconsistent with an obligation placed on them under that Act, e.g. requirement to live somewhere else because they are on leave of absence from detention or subject to guardianship, supervised community treatment or conditional discharge. If proposed authorisation relates wholly or partly to treatment of mental disorder then need to consider the individual's objection to treatment and whether they meet criteria for detention	Approved mental health practitioner or registered medical practitioner approved under Section 12 of the Mental Health Act
Best interests	To establish whether deprivation of liberty is occurring or going to occur and if it is in the best interests of the relevant person. Is it necessary to prevent harm and is it a proportionate response to the likelihood and seriousness of that harm?	Approved mental health practitioner or other professional such as social worker, nurse, occupational therapist or psychologist with appropriate level of experience and competencies

MCQ answers

1 c 2 b 3 b 4 c 5 c

be subject to the provisions of either of the Acts. It will be the responsibility of the eligibility assessor (either a best interests assessor who is an approved mental health professional or a mental health assessor who is Section 12(2) approved) to decide whether it is appropriate to use the deprivation of liberty safeguards procedures or whether detention under the Mental Health Act would be more appropriate. Briefly, the relevant person will be ineligible for authorisation under the provisions of the deprivation of liberty safeguards procedures if he is or ought to be detained under the Mental Health Act 1983 or the proposed course of action would be in conflict with the compulsory regime to which he is subject, for instance where he is to live. Box 4 lists a range of considerations that professionals must regard when considering the limits of the Mental Capacity Act and therefore whether they are eligible for a deprivation of liberty authorisation.

The legal landscape is changing in how eligibility is interpreted. Following the complex judgment

in *GJ v. The FT and the PCT and the Secretary of State for Health* [2009] it seems that there may be a significant move towards the use of the Mental Health Act in hospital settings, given what would seem to be a low threshold for considering what constitutes an objection to treatment and diminishing the use of the Mental Capacity Act when the Mental Health Act is available.

Responsibilities of the supervisory body

The supervisory body may not give authorisation unless all of the assessments are supportive. When granted, there are a number of steps that must be taken by the supervisory body. It must specify the duration of the authorisation, which must not exceed 12 months or be longer than the recommendation of the best interests assessor. The supervisory body may attach conditions to the authorisation with which the managing authority are obliged to comply. There must be written notice given to specified people to inform them of the decision and a relevant person's representative must be appointed. The supervisory body can be required to review the authorisation at any time by the relevant person, their representative or any independent mental capacity advocate representing the person and a review can be initiated if there has been a significant change in circumstances and, if appropriate, revoke it before it expires. If it is reported to a supervisory body that a person is believed to be unlawfully deprived of their liberty, a best interests assessor must be appointed to investigate the situation within 7 days followed by a full standard authorisation assessment process.

BOX 4 Considering whether to treat a person who lacks capacity

Circumstances where the Mental Health Act may be required to detain and treat somebody who lacks capacity to consent to treatment, rather than use the Mental Capacity Act (see Department for Constitutional Affairs 2007: Chapter 13):

- the relevant person is under 18 (the Children Act 1989 may be appropriate)
- it is not possible to give the person the care or treatment they need without depriving them of their liberty
- treatment cannot be given under the Mental Capacity Act because the person has made a valid and applicable advance decision to refuse an essential part of treatment
- the treatment would conflict with a decision of the relevant person's attorney, court-appointed deputy or a court ruling
- the person may need to be restrained in a way that is not allowed under the Mental Capacity Act
- it is not possible to assess or treat the person safely or effectively without treatment being compulsory, perhaps because the person is expected to regain capacity to consent and then to refuse to give it
- the person lacks capacity to decide on some elements of the treatment but has capacity to refuse a vital part of it – and they have done so
- there is some other reason why the person might not get treatment and they or somebody else might suffer harm as a result

Conclusions

Before the judgment in *HL v. United Kingdom* [2004], a critical concern with respect to a person lacking decision-making capacity to consent to hospital admission was whether they were objecting or not. Since then, the question of rights and safeguards of incapacitated people have reached a pre-eminent position. To prevent unlawful and arbitrary deprivation of liberty of this group of individuals and meet the requirements of the European Convention on Human Rights the government considered a range of options, including extending the powers under guardianship in the Mental Health Act but ultimately adopting the 'protective care' afforded by the deprivation of liberty safeguards. The foreword to the *Deprivation of Liberty Safeguards: Code of Practice* (Department of Health 2008) highlights the seriousness of depriving someone of their liberty, but the mechanisms of its authorisation are complex and the interface with the Mental Health Act may be

confusing. Although the government estimated that there would be approximately 21 000 assessments in the first year up to September 2009 (Ministry of Justice 2008), only 3527 requests for a standard authorisation were received (14% of the original estimate). It remains to be seen whether the complexity of the safeguards has discouraged their use or what other factors are influential.

Importantly, the rights and safeguards under the provisions of the two Acts are different. There is no statutory right of appeal to an equivalent of a mental health review tribunal. Access to the Court of Protection will be limited and may rely on a concerned person lodging an application. It seems likely that there will be few challenges to the process and quality assurance of decision-making may be difficult to verify. The English and Welsh government's insistence on revising the Mental Capacity Act rather than the Mental Health Act has led to the development of a scheme that is complex and legalistic. In consequence, the very individuals whom the safeguards purport to protect may not be subject to the provisions and those who are made subject to a deprivation of liberty authorisation will receive poorer safeguards and benefits than those subject to the Mental Health Act.

Finally, a source of potential conflict will be the striking disparity in funding arrangements between those who are, or have been, detained under the Mental Health Act and subject to the funded aftercare arrangements of section 117 and those who are detained under the Mental Capacity Act whose care will be means-tested. This seems unfair and it will be interesting to take note of how the preferences of relatives and carers evolve

as the public become more discerning concerning this issue given the importance of the financial stakes involved.

Additional information

Online training on the deprivation of liberty safeguards is available from the Royal College of Psychiatrists at www.e-lfh.org.uk/projects/dols/register.html.

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MCQs

Select the single best option for each question stem

1 The deprivation of liberty safeguards:

- a were introduced to prevent deprivation of liberty in a person's own home
- b facilitate protection of people other than the relevant person from harm
- c a primary care trust may be responsible for providing the appropriate standard authorisation
- d the supervisory body issues an urgent deprivation of liberty authorisation.

2 The medical assessor may be called on to:

- a undertake a best interests assessment
- b perform an assessment of the relevant person's mental capacity, for instance, in relation to a residency decision

- c decide whether the relevant person is over 18

- d decide whether a deprivation of liberty authorisation will conflict with a valid and applicable advance directive.

3 Detention under the Mental Health Act 1983 may be more appropriate to consider as an alternative to the deprivation of liberty safeguards in the following circumstances:

- a to provide physical care for the relevant person
- b where a person may require repeated restraint
- c where the relevant person lacks capacity to make an informed decision regarding care and treatment
- d where there is no valid and applicable advance directive.

4 To prevent deprivation of liberty occurring:

- a there is no requirement to consider what restrictions are placed before entry into a care home
- b involvement of advocacy services should be avoided
- c it is vital to consider all aspects of the care plan
- d there is no need to involve carers or relatives in planning care.

5 The best interests assessor:

- a must be a social worker
- b may authorise deprivation of liberty exceeding a year
- c must provide relevant information to the medical assessor
- d may not undertake the mental capacity assessment.