UNDERSTANDING THE INTERFACE BETWEEN THE MENTAL CAPACITY ACT'S DEPRIVATION OF LIBERTY SAFEGUARDS (MCA-DOLS) AND THE MENTAL HEALTH ACT (MHA)

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Understanding the interface between the Mental Capacity Act's Deprivation of Liberty Safeguards (MCA-DoLS) and the Mental Health Act (MHA)

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EXECUTIVE SUMMARY

The background to the Mental Capacity Act's Deprivation of Liberty Safeguards (the MCA-DoLS) regulations, which were introduced in 2009, lies in the European Convention on Human Rights. Their aim is to protect adults with a mental disorder who lack capacity to make decisions about arrangements for their care and treatment in psychiatric or general ('acute') hospitals and care homes and may be at risk of having limits that go beyond mere restriction or restraint placed on their freedom of movement. According to the regulations that set out the MCA-DoLS procedure, a deprivation of liberty, which must always be in the 'best interests' of the person to whom it applies, can only be authorised by an independent body, the Supervisory Body, following an application by a Managing Authority on behalf of a clinical team and the completion of six assessments. In contrast with care homes, in settings such as psychiatric hospitals where the Mental Health Act (MHA) can also be used, a decision may need to be made between the two statutory frameworks for civil detention.

In order to provide recommendations for policy and practice, we set out to examine, first, how practitioners make decisions between the MCA-DoLS and the MHA, and, secondly, the characteristics of, and outcomes for, men and women for whom applications for, and authorisations of, a deprivation of liberty are made. The study, which was carried out from November 2010 to November 2011 used information from a number of sources. Three Supervisory Bodies, covering an ethnically diverse population of 1.7 million across metropolitan, urban, and rural areas provided anonymised completed copies of the Department of Health's standard application and key assessment Forms. We also analysed the text of other standard Forms; carried out semi-structured interviews with individuals with key roles in the application, assessment and/or authorisation process; presented brief clinical vignettes to psychiatrists and others; attended events and meetings with practitioners; and held discussions with representatives of the three Supervisory Bodies to confirm issues relating to emerging themes. In addition, data relating to the MCA-DoLS from the Health and Social Care Information Centre were collected and compared with information about the use of the MHA in order to examine and compare the characteristics and experiences of men and women subject to the two different legal frameworks.

While concerns were expressed by practitioners regarding, for example, the Code of Practice and the status of guidance that is occasionally issued by the Department of

Health, there was also some support for the MCA-DoLS and its potential for safeguarding men and women whose lack of decision-making capacity makes them vulnerable. Nevertheless, our findings suggested a range of difficulties, extending beyond the interface with the MHA. The decision-making of clinicians in psychiatric hospitals was strongly oriented to the MHA as the appropriate legal framework for patients receiving what they described as 'active treatment' (medication, ECT, psychological interventions). The MCA-DoLS were seen as appropriate for detaining men and women receiving what they termed 'care' (support with personal care and/or everyday tasks) while awaiting discharge to residential accommodation. It was reported that, in contrast, medical practitioners in general hospitals seemed reluctant to consider the MHA even when it appeared appropriate for the treatment of their patients' mental disorders.

In both applications for assessments for the MCA-DoLS and in the Best Interests Assessments, restrictions and particularly restraint, patient challenges, and the family's wish for the relevant person to return home with them, were used rather crudely as indicators of a deprivation of liberty. However, like clinicians, Best Interests Assessors did not always recognise that, in the context of treatment for a mental disorder, patient opposition and subsequent staff restrictions could constitute 'objection' for which the use of the MHA might need to be considered. We found little evidence of a consideration of less restrictive alternatives such as environmental modifications that might limit the extent to which restrictions might need to be placed on a patient's freedom of movement.

Aspects of the standard Forms that practitioners have to complete are unhelpful: they are repetitive, contain wording that is slightly misleading, and do not ensure that the process of decision-making for the MCA-DoLS is always transparent and challengeable. There was evidence from completed Forms that arrangements for the provision of care and treatment were conflated with the care and treatment itself. More than a third of the thirty-seven *Form 4*s completed by Managing Authorities did not attach a copy of the care plan, which should contain details not only of the patient's care and treatment but also the arrangements for the provision of that care and treatment. Of concern, while almost three-quarters of the *Form 10*s completed by Best Interests Assessors referred to consultations with 'interested parties', only one referred directly to the information gained. This meant that the voices and insights of those who might have long-standing knowledge of the person on whose behalf a deprivation of liberty was being sought were missing.

While the format of the data set placed severe restrictions on our analysis, we found that applications and authorisations for MCA-DoLS for patients in general and psychiatric

hospitals were mainly made on behalf of people aged 65 years or more, with a diagnosis of dementia. There were slight differences between these individuals and their counterparts in care homes: in care homes, a greater proportion of applications and authorisations were for women. In both hospitals and care homes, only a small proportion of men and women subject to the MCA-DoLS had a learning disability. The extent to which individuals subject to the regulations could be compared with other groups was very limited but we found that, compared with people admitted informally or detained under s. 3 of the Mental Health Act for treatment of a mental disorder, men and women subject to the MCA-DoLS were older and more likely to be male. Encouragingly, there was no evidence of an over-representation under the MCA-DoLS of people from ethnic minority backgrounds. Of concern, however, almost no one subject to the MCA-DoLS initiated a review him or herself, highlighting the need for support for this group of men and women.

Our findings suggest that the interface between the MCA-DoLS and the MHA is not well-understood. We propose that this reflects, first, the fundamental differences between the principles and scope of, and criteria for, the MCA and the MHA. Secondly, however, there appears also to be some lack of appreciation that both Acts exist to allow actions to be taken on behalf of another person that would normally be seen as a gross infringement of his or her right to self-determination. Both the MCA and the MHA need to be used in a way that is transparent, justifiable, defensible, and challengeable. In addition to making some suggestions about further research, our recommendations focus on alleviating the difficulties to which our study has drawn attention. These recommendations are summarised below.

1: Strengthen attention to decision-making capacity in psychiatric as well as general hospitals

Patients' capacity to make decisions about their care and treatment and the arrangements for providing that care and treatment should be assessed in psychiatric as well as general hospitals, regardless of whether or not the person is detained under the Mental Health Act; the principles of the Mental Capacity Act apply to all patients and should be seen as good practice; capacity and limits placed on freedom of movement should be documented in care plans; to enhance access to relevant safeguards, consideration should be given to the extension of the Independent Mental Capacity Advocacy role to informal patients who lack capacity to their admission and/or their treatment and are admitted to a psychiatric hospital.

2: Revise the standard Forms

The Forms should help practitioners to make clear the reasons for their decisions. A number of specific changes are proposed and we suggest that consideration is given to a

reduction in the number of Forms. Any revisions would benefit from strong practitioner involvement in their development and piloting.

3: Revise and update the MCA-DoLS Code of Practice and clarify the status of guidance issued by the Department of Health

The revisions should include an emphasis on the prevention of deprivations of liberty, for example, by holding a 'best interests' meeting to consider how best to maintain a patient's freedom of movement before any request is made for a Standard Authorisation; guidance on the possibility of using restrictions under s. 6 of the Mental Capacity Act; further clinical examples, reflecting the complexity of the situations encountered by practitioners and relating not only to the interface between the MCA-DoLS and the MHA, but also to the interface between each of these and the MCA. Implementation of this recommendation would benefit from the involvement of clinicians as well as those with formal roles in the MCA-DoLS procedure. Practitioners would also benefit from clarification of the status of the guidance about the interpretation of relevant case law that is occasionally issued by the Department of Health.

4: Review and improve the data collection and monitoring procedures

Individual level, rather than aggregated, data should be collected; the information should include the type of setting from which the application is made; applications and authorisations should, ideally, be linked; data should be collected about the outcome of reviews. Encouragingly, some of the changes that we have recommended may be implemented by the Health and Social Care Information Centre during 2013-2014.

Details of these recommendations, and suggestions for further research, are provided in the text for the report.

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CONTENTS

CHAPTER 1: BACKGROUND

1.1 Introduction

1.1.1 This Chapter sets out the Department of Health's terms of reference for our study and introduces the Mental Capacity Act's Deprivation of Liberty Safeguards (MCA-DoLS). We then outline the frameworks for the provision of mental health treatment in mental health settings in England and Wales before considering the challenges that practitioners face in negotiating the interface between the MCA-DoLS and the Mental Health Act (1983, as amended, 2007; hereafter, the MHA). While the focus is this interface, the challenges need to be viewed in the broader context of the MCA-DoLS.

1.2 Terms of reference and our approach

1.2.1 The study was commissioned by the Department of Health to examine the interface between the Mental Capacity Act's Deprivation of Liberty Safeguards (the MCA-DoLS) and the Mental Health Act 1983 (as amended 2007; the MHA) in order to make recommendations that might contribute to the development of policy and practice. The brief invited us to examine two main sets of issues, which we consider in Chapters 3 and 4, respectively: a) *Practitioners' understanding of the interface*, including (i) their understanding of the interface in respect of people needing mental health treatment in hospital; (ii) the way in which they make decisions between the two Acts; and (iii) the perceived usefulness of the Codes of Practice for the MCA-DoLS and the MHA in interpreting and applying the interface; and b) *The effects of the interface* through (i) describing the characteristics of people in hospital for treatment under the MHA and 'for the same reason' under the MCA-DoLS; (ii) assessing whether the choice of legislation is associated with any differences in an individual's care or treatment or his or her outcome; (iii) the extent to which the MCA-DoLS is used to keep in hospital people who would previously have been detained under the MHA; and (iv) the frequency of, and any challenges resulting from, transitions between the MHA and the MCA-DoLS.

1.2.2 To address the research issues, we adopted an approach that was both qualitative and quantitative. Data collection was carried out between November 2010 and

November 2011, in England. In preparing this report, we have made some reference, where it has appeared relevant, to case law and other material that has appeared following the end of our data collection.

1.2.3 The recommendations we make at the end of this report focus on addressing the practical problems we identified.

1.2.4 It should be noted that the interface between the MCA-DoLS and the MHA is not limited to traditional mental health settings such as psychiatric units and hospitals[1] (which we have called 'psychiatric hospitals'). Regardless of their commissioning arrangements, general ('acute') hospitals, nursing homes, and other settings with the appropriate registration can accept men and women under both the MHA and the MCA. Care homes, as the term is used here, are residential establishments that are not registered for the use of the MHA. While the interface with the MCA-DoLS does not need to be considered in care homes, issues relating to practitioners' understanding of the procedure, and of the MCA of which they form a part, are relevant to this setting.

1.2.5 In contrast with care homes and other settings providing short- or long-term accommodation in an as ordinary environment as possible, psychiatric and general hospitals are designed specifically for the purpose of assessing and/or treating a mental or physical disorder; they are not intended to provide social care. Since this report primarily concerns the interface between the MCA-DoLS and MHA in hospitals, throughout this report we use the term 'patient' to refer to the men and women for whom applications under the MCA-DoLS are made or authorised.

[1] The definition of 'hospitals' and 'care homes' is the one used in the Mental Capacity Act (s. 38 (6) and (7)); see Care Quality Commission (2012). *The operation of the Deprivation of Liberty Safeguards in England, 2010/11*, p. 3. London: The Care Quality Commission.

1.3 Frameworks for the provision of mental health assessment and treatment in hospital in England and Wales

Figure 1.1: The different frameworks for the civil provision of mental health assessment and treatment in hospital in England and Wales.

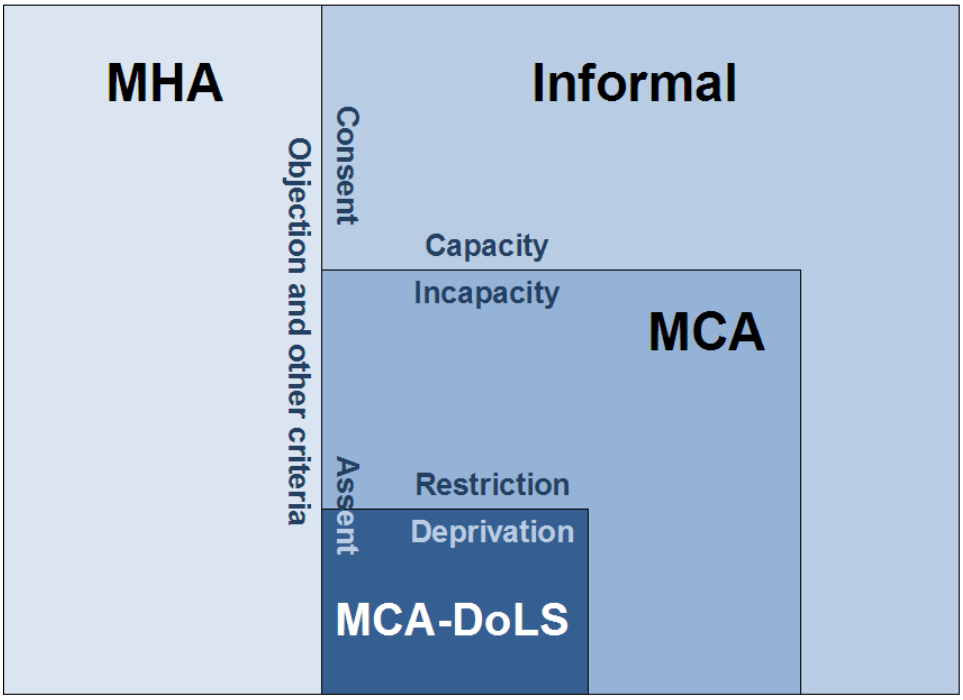

Figure 1.1 represents the different frameworks and their interfaces, and key issues to be considered in using one, rather than another, framework[2,3,4]

1.3.1 *Detention under the MHA*. The MHA provides the legal framework in England and Wales for the provision of 'medical treatment' - through compulsory admission to and detention in a psychiatric hospital if necessary - of men and women with a 'mental disorder' of the necessary 'nature or degree' (ss. 2 and 3) who present a risk to themselves or others. The definition of 'medical treatment' is very broad, and includes acts that are ancillary to the 'core' treatment (*B v Croydon HA*[5]) and need only be 'appropriate' to the particular circumstances of the person's mental disorder. With some exceptions, decisions about 'medical treatment',' can be made on behalf of

2 Mental Health Act Commission (2007). *Key findings about the use of the Mental Health Act* (12th Biennial Report). London: The Stationery Office.

3 Owen, G. S., Richardson, G., David, A. S., Szmukler, G., Hayward, P., & Hotopf, M. (2008). Mental capacity to make decisions on treatment in people admitted to psychiatric hospitals: cross sectional study. *British Medical Journal*, *337*(7660), pp.40-42.

4 The relative sizes of the blocks labelled MHA, Informal or Capacity are approximations based on evidence (see ns. 1, 2, respectively). The proportion of informal patients who are subject to restrictions, which, in some cases, may amount to a deprivation of liberty, is unknown.

5 *B v Croydon HA* [1995] sub.nom. *LB v Croydon HA* [1995] 2 W.L.E.294.

this group of patients without any consideration of their capacity to give or withhold consent to remaining in hospital or to the treatment itself. However, unless it is connected to the mental disorder and intended to alleviate the symptoms or the underlying cause of that disorder (*B v Croydon HA*[6]), treatment for a physical disorder is not permitted under this legislation. Several aspects of the MHA remain controversial but the legal framework has become well-established over many years and is compatible with the European Convention on Human Rights.

1.3.2 *Admission and treatment under common law*. The majority of patients in hospital are not detained under the MHA but are 'informal', and are admitted to, and treated, in hospital under common law. Men and women with the capacity to consent to their admission and treatment, and who give that consent, are considered to have provided a valid agreement to remaining in hospital (see *Storck v Germany*[7]).

1.3.3 *Admission and treatment under the MCA*. It has become increasingly clear, however, that, like many in-patients in general hospitals[8], a significant proportion of informal patients in psychiatric hospitals do not have the capacity to consent to their admission[9,10] and/or their treatment[11,12.] Identifying these patients is not always easy, but the most extensive study[13] suggests that about one in four adult in-patients in psychiatric hospitals are both informal *and* lack capacity to consent to remaining there for treatment.

1.3.4 The MCA provides a statutory framework for decision-making on behalf of these patients. Its purpose is to empower as well as safeguard adults who lack capacity to make one or more decisions for themselves. There is a presumption of capacity, so to be eligible for the MCA adults must have both an 'impairment of, or a disturbance in the functioning of, the mind or brain' (s2(i)) *and* lack the capacity to make a

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6 *B v Croydon HA*, *op. cit*., n. 5.

7 *Storck v Germany* (2006) 43 E.H.R.R. 96, para 74.

8 Raymont, V., Bingley, W., Buchanan, A., David, A. S., Hayward, P., Wessely, S., & Hotopf, M. (2004). Prevalence of mental incapacity in medical inpatients and associated risk factors: cross-sectional study. *The Lancet*, *364(9443)*, pp. 1421-1427.

9 Bellhouse, J., Holland, A. J., Clare, I. C. H., Gunn, M., & Watson, P. (2003a). Capacity-based mental health legislation and its impact on clinical practice: 1) admission to hospital. *Journal of Mental Health Law*, *August*, pp. 9-23.

10 Mukherjee, S., & Shah, A. (2001) The prevalence and correlates of capacity to consent to a geriatric psychiatry admission. *Aging & Mental Health*, *5*, pp. 335-339.

11 Bellhouse, J., Holland, A.J., Clare, I.C H..Gunn,M., & Watson, P. (2003b). Capacity-based mental health legislation and its impact on clinical practice: 2) treatment in hospital. *Journal of Mental Health Law*, *August*, pp. 24-36.

12 Owen et al. (2008), *op. cit*., n. 3.

13 Owen et al. (2008), *ibid.*

necessary decision, or carry out a necessary act, for themselves. The scope of decision-making in the 'best interests' of the person who lacks capacity is constrained in several ways, most importantly, by any previous valid advance treatment refusals and by valid refusals by donees or deputies acting on behalf of the person lacking capacity. In contrast with the MHA, the MCA applies to all settings and to a broad range of decisions, including decisions relating to the care and treatment of mental and physical health disorders.

1.3.5 Under the MCA, restrictions and restraint, including restraint that restricts the person's freedom of movement, are lawful (under s. 6), provided that it is believed to be both 'necessary', and that it is proportionate to (i) the risk of the person coming to harm; and (ii) the severity of that harm.

1.3.6 However, some informal patients may be subject to more onerous restrictions or restraint, which amount to a 'deprivation of liberty'. This group of men and women are very vulnerable because they lack the capacity to give consent to their admission to hospital and/or their treatment there and may be unlikely to challenge the limitations placed on their freedom. Before 2009, such patients were detained in psychiatric hospitals under common law, on the grounds of necessity. In a landmark case, the European Court of Human Rights in *HL v UK*[14] ruled that the absence of procedural safeguards and access to appropriate review under this framework violated art. 5 (the right to liberty) under the European Convention on Human Rights. The MCA-DoLS were introduced to remedy these violations. They ensure that, like the MHA, the MCA is compliant with the ECHR without the need to refer each case to the Court of Protection.

1.3.7 As Fig. 1.1 shows, the introduction of the MCA-DoLS procedure means that, for some patients, a decision may have to be made between the two statutory frameworks for civil detention: compulsory detention under the MHA and a deprivation of liberty under the MCA-DoLS. This is what is known as the MCA-DoLS and MHA interface. In contrast with other decision-points in the framework, which rely on the characteristics or the behaviour of the patient (capacity, objection, mental disorder of a sufficient 'nature or degree'), decisions about a deprivation under the MCA-DoLS depend, in part, on the environment in which care and treatment will be provided.

[14] *HL v The United Kingdom* [2004] 40 E.H.R.R. 761.

1.3.8 From the first, the MCA-DoLS regulations were also extended to care homes as a form of adult safeguarding for vulnerable residents. Many of the practitioners involved in the authorisation of the MCA-DoLS will be working both in settings in which the MHA can be applied and those (primarily, care homes) in which it cannot.

1.4 The MCA-DoLS regulations

1.4.1 The MCA-DoLS regulations were introduced into the MCA through an amendment to the MHA, and came into force in England and Wales, on 1st April, 2009. Sch.A1 of the MCA comprises regulations setting out a procedure that applies not only to appropriately registered settings in which the MHA can be used (primarily, but not exclusively, psychiatric hospitals) but also to other settings, the most important of which are general ('acute') hospitals.

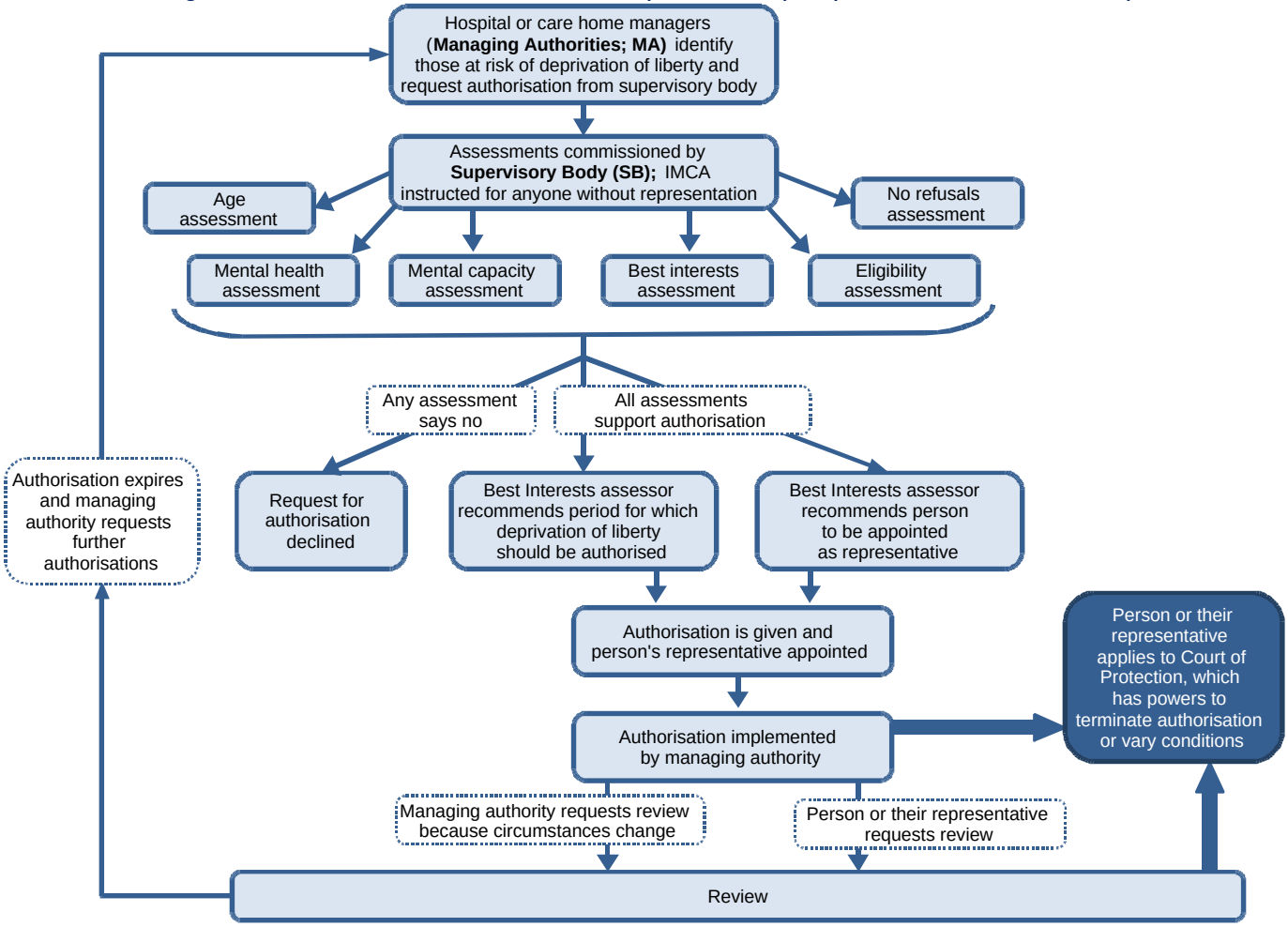
1.4.2 The procedure, which applies to adults (a) aged 18 years or more; with (b) a 'mental disorder'; who (c) lack the capacity to consent to the arrangements made for the provision of their care or treatment; but (d) (in settings in which the MHA could be used) do not appear to object to them; for whom (e) detention (a 'deprivation of liberty') to provide that care or treatment may be necessary in their 'best interests' and to protect them from harm, comprises (i) an application by a Managing Authority (often represented, in a hospital setting, by the senior nurse or ward manager) for an authorisation of a possible detention (deprivation of liberty); (ii) the commissioning, by an independent body, the Supervisory Body of assessments (up to 31st March, 2013, these Supervisory Bodies were based in PCTs and local authorities; since 1st April, 2013, they have been based in local authorities); (iii) the authorisation of a detention (if all the assessments agree) by the Supervisory Body; (iv) access to the Court of Protection to challenge the lawfulness of the detention; and (v) a system of independent monitoring of the implementation of the MCA-DoLS through the Care Quality Commission (CQC).

1.4.3 Sch.A1 is accompanied by guidance, provided in a supplement to the MCA Codes of Practice (MCA-DoLS Code of Practice[15]; hereafter, CoP). An overview of the procedure is provided in Annex 1 of the CoP. This is presented, with minor

[15] Ministry of Justice (2008). *Mental Capacity Act 2005: Deprivation of liberty safeguards – Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice*. London: The Stationery Office.

amendments to clarify the process, as Fig. 1.2. Detailed guidance about different aspects of the procedure is set out in subsequent Annexes (see CoP).

Figure 1.2: Overview of the MCA-DoLS procedure (adapted from Annex 1, CoP)

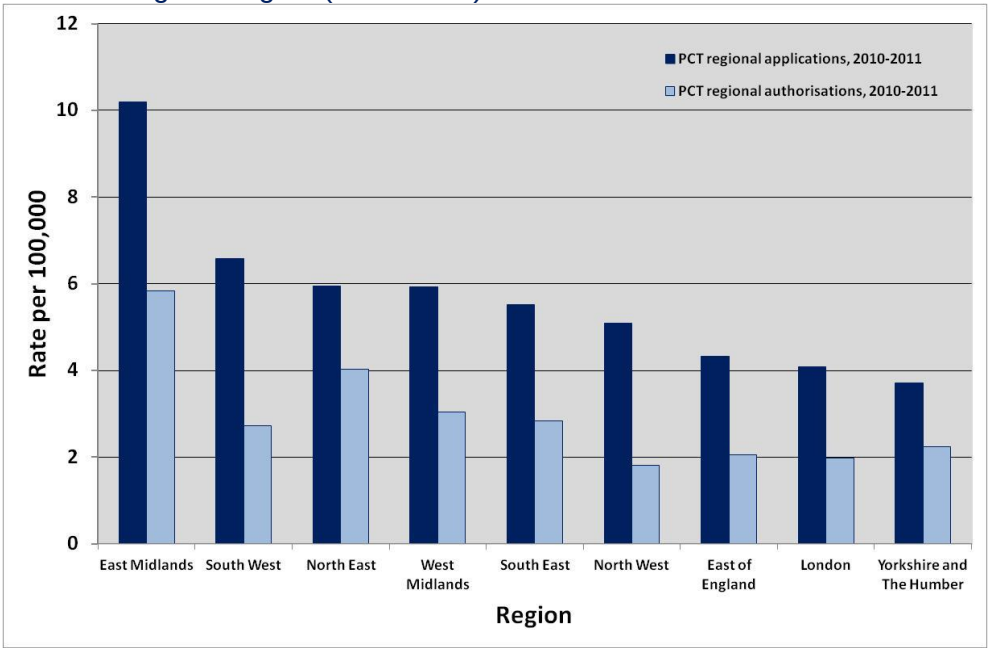


1.4.4 Even before its introduction, there were considerable concerns about the MCA-DoLS regulations and the procedure they set out[16,17]. The regulations were thought to be conceptually confusing and the procedure so complex that it was hard to understand. There was anxiety that it would be difficult for practitioners, who were expected to identify possible deprivations of liberty and make applications for assessments, to understand and implement. Since its introduction, the range of concerns, which has been widely disseminated, has broadened, encompassing many aspects of the MCA-DoLS regulations and procedure[18,19,20,21,22].

16 Bowen, P (2007). *Blackstone's Guide to The Mental Health Act 2007*. Oxford: Oxford University Press.
17 Richardson, G. (2010). Mental capacity at the margin: The interface between two Acts. *Medical Law Review*, *18*(1), p. 56-77.
18 Care Quality Commission (2012), *op. cit.,* n. 1.
19 Jones, R.M. (2011). *Mental Health Act Manual (14th edition)*. London: Sweet & Maxwell Ltd.

1.4.5 The concerns *appear* to have some support. We have calculated the rates of applications from PCTs[23], authorisations and daily average of individuals subject to a deprivation for 2010-2011 in different Regions.

Figure 1.3: Rates of applications for the MCA-DoLS by Managing Authorities in PCTs, authorisations and daily average number of individuals subject to a deprivation for each English Region (2010-2011)[24,25,26,27]



[20] Jones, R.M. (2012). *Mental Capacity Act Manual (5th edition)*. London: Sweet & Maxwell Ltd.

[21] Hargreaves, R. (2011). *The Deprivation of Liberty Safeguards*. London: The Mental Health Alliance.

[22] Szerletics, A., & O'Shea, T. (2011). *The Deprivation of Liberty Safeguards. Essex Autonomy Project Briefing (Updated February 2011).* Essex: University of Essex.

[23] Under the Health and Social Care Act 2012, PCTs, which currently commission hospital services, were abolished, and their role taken over on 1st April 2013 by Clinical Commissioning Groups.

[24] Health and Social Care Information Centre (2010a). *Quarterly analysis of Mental Capacity Act 2005, Deprivation of Liberty Safeguards (DoLS) Assessments (England) - Quarter 1 2010/11.* Leeds: The Health and Social Care Information Centre. Available at: http://www.hscic.gov.uk/searchcatalogue?productid=2516&q=Quarterly+analysis+of+Mental+Capacity+Act+2005%2c+Deprivation+of+Liberty+Safeguards+%28DoLS%29+Assessments+%28England%29&sort=Relevance&size=10&page=1#top.

[25] Health and Social Care Information Centre (2010b). *Quarterly analysis of Mental Capacity Act 2005, Deprivation of Liberty Safeguards (DoLS) Assessments (England) - Quarter 2 2010/11.* Leeds: The Health and Social Care Information Centre. Available at: http://www.hscic.gov.uk/searchcatalogue?productid=2519&q=Quarterly+analysis+of+Mental+Capacity+Act+2005%2c+Deprivation+of+Liberty+Safeguards+%28DoLS%29+Assessments+%28England%29&sort=Relevance&size=10&page=1#top.

[26] Health and Social Care Information Centre (2011a). *Quarterly analysis of Mental Capacity Act 2005, Deprivation of Liberty Safeguards (DoLS) Assessments (England) - Quarter 3 2010/11.* Leeds: The Health and Social Care Information Centre. Available at: http://www.hscic.gov.uk/searchcatalogue?productid=2522&q=Quarterly+analysis+of+Mental+Capacity+Act+2005%2c+Deprivation+of+Liberty+Safeguards+%28DoLS%29+Assessments+%28England%29&sort=Relevance&size=10&page=1#top.

[27] Health and Social Care Information Centre (2011b). *Quarterly analysis of Mental Capacity Act 2005, Deprivation of Liberty Safeguards (DoLS) Assessments (England) - Quarter 4 2010/11.* Leeds: The Health and Social Care Information Centre. Available at: http://www.hscic.gov.uk/searchcatalogue?productid=2527&q=Quarterly+analysis+of+Mental+Capacity+Act+2005%2c+Deprivation+of+Liberty+Safeguards+%28DoLS%29+Assessments+%28England%29&sort=Relevance&size=10&page=1#top.

Fig. 1.3 indicates considerable variations in different Regions. While there are other possible explanations (for example, population demographics, or the impact of the use of the MHA), one possibility is that the MCA-DoLS is being interpreted differently by Managing Authorities and/or Supervisory Bodies in different Regions.

1.4.6 Regardless of the setting in which the MCA-DoLS is used, practitioners may be presented with two major sets of challenges. The first set is practical. The MCA-DoLS procedure has required the establishment of a new system: the development of new organisations: Supervisory Bodies for PCTs and local authorities (often combined, even before 1st April 2013), monitored by the Care Quality Commission; extensions of existing roles within the MCA (for IMCAs); new roles for psychiatrists and other s.12 approved (or eligible) medical practitioners (as Mental Health, Mental Capacity and/or Eligibility Assessors) and for AMHPs (as Mental Capacity, Eligibility, Age, No Refusals and Best Interests Assessors); and the creation of a new role for a wide range of practitioners: Best Interests Assessors. For Supervisory Bodies, the task of organising the six assessments necessary for an authorisation (within 7 days for an urgent authorisation) can be difficult to achieve and each application, particularly if it is authorised, can generate a good deal of documentation. Table 1.1 shows the list of standard Forms issued by the Department of Health to accompany the introduction of the procedure. Local variations are to these Forms are permitted but must record the same information.

Table 1.1: MCA-DoLS: List of standard Forms used in the application, authorisation and review process

Form No.	Title
1	Urgent Authorisation
2	Request for Extension of Urgent Authorisation
3	Supervisory Body's Decision Concerning Request for Extension of Urgent Authorisation
4	Request for a Standard Authorisation
5	Age Assessment
6	Mental Health Assessment
7	Mental Capacity Assessment
8	No Refusals Assessment
9	Eligibility Assessment
10	Best Interests Assessment
11	Record that an Equivalent Assessment is Being Used; Standard Authorisation Procedure
12	Supervisory Body's Decision; Standard Authorisation
13	Supervisory Body's Decision; Standard Authorisation Not Granted
14	Suspension of a Standard Authorisation
15	Notice that a Suspension has been Lifted
16	Unauthorised Deprivation of Liberty; Notice that a Request has been Received
17	Unauthorised Deprivation of Liberty; Assessor's Report
18	Unauthorised Deprivation of Liberty; Supervisory Body's Decision
19	Request for a Review by the Managing Authority
20	Notice that a Review is to be Carried Out
21	Supervisory Body's Decision as to Whether any Qualifying Requirements are Reviewable
22	Supervisory Body's Decision; Following Review Assessment(s) under Part 8 of Schedule A1 to the Mental Capacity Act 2005
23	Standard Authorisation has Ceased to be in Force
24	Selection of a Representative
25	Appointment of a Representative
26	Notice of the Pending Termination of your Appointment as a Representative
27	Termination of a Representative's Appointment
28	Best Interests Assessor Referral Form
29	Mental Health Assessor Referral Form
30	IMCA Referral Form
31	IMCA Report Form
32	Record of Assessments, Authorisations and Reviews

1.4.7 The first set of challenges is likely to have most impact upon the representatives of Supervisory Bodies. In contrast, practitioners in clinical teams, Managing Authorities, and also Assessors, are most likely to be affected by the second set of challenges. The task of identifying a possible deprivation of liberty, making an application for, and carrying out, the necessary assessments involves the translation and

application of complex and evolving legal concepts into clinical practice. In mental health settings, this task is likely to be particularly difficult because, for some patients, decisions must be made between the use of one or the other statutory frameworks for civil detention.

1.5 Three complex legal concepts

1.5.1 In this section we highlight three of the concepts that were frequently raised by Managing Authorities, Assessors and representatives of Supervisory Bodies in the development of the study to illustrate the challenges that practitioners face. The first two: (i) eligibility; and (ii) objection are relevant to the interface between the MCA-DoLS and the MHA; the third (iii) deprivation of liberty applies to the MCA-DoLS in all settings.

1.5.2 *Eligibility*: To try to ensure that the MCA-DoLS should not be seen as an alternative method of detention in circumstances in which the MHA already provides the appropriate legal framework, a second schedule, Sch.1A, was inserted into the MCA, to provide guidance on eligibility. The schedule sets out five cases (A-E) in which a patient for whom a request for authorisation of a deprivation of liberty has been made will be *in*eligible for the MCA-DoLS. An adapted version of the five cases is shown as Table 1.2.

Table 1.2: Table to determine ineligibility for the MCA-DoLS (adapted from Sch.1A, para.2)

	Status of P	Determination of ineligibility
Case A	P is – (a) subject to the hospital treatment regime, and (b) detained in a hospital under that regime.	P is ineligible.
Case B	P is – (a) subject to the hospital treatment regime, but (b) not detained in a hospital treatment regime.	**3 Authorised course of action not in accordance with regime** 1. This paragraph applies in cases B, C and D. 2. P is ineligible if the authorised course of action is not in accordance with a requirement which the relevant regime imposes. 3. That includes any requirement as to where P is, or is not, to reside. 4. The relevant regime is the mental health regime to which P is subject. **4 Treatment for mental disorder in a hospital** 1. This paragraph applies in cases B and C. 2. P is ineligible if the relevant care or treatment consists in whole or in part of medical treatment for mental disorder in a hospital.
Case C	P is subject to the community treatment regime.	**3 Authorised course of action not in accordance with regime** 1. This paragraph applies in cases B, C and D. 2. P is ineligible if the authorised course of action is not in accordance with a requirement which the relevant regime imposes. 3. That includes any requirement as to where P is, or is not, to reside. 4. The relevant regime is the mental health regime to which P is subject. **4 Treatment for mental disorder in a hospital** 1. This paragraph applies in cases B and C. 2. P is ineligible if the relevant care or treatment consists in whole or in part of medical treatment for mental disorder in a hospital.

Case D	P is subject to the guardianship regime	**3 Authorised course of action not in accordance with regime** 1. This paragraph applies in cases B, C and D. 2. P is ineligible if the authorised course of action is not in accordance with a requirement which the relevant regime imposes. 3. That includes any requirement as to where P is, or is not, to reside. 4. The relevant regime is the mental health regime to which P is subject. **5 P objects to being a mental health patient etc** 1. This paragraph applies in cases D and E. 2. P is ineligible if the following conditions are met. 3. The first condition is that the relevant instrument authorises P to be a mental health patient. 4. The second condition is that P objects— 5. To being a mental health patient, or 6. To being given some or all of the mental health treatment. 7. The third condition is that a donee or deputy has not made a valid decision to consent to each matter to which P objects. 8. In determining whether or not P objects to something, regard must be had to all the circumstances (so far as they are reasonably ascertainable), including the following— 9. P's behaviour; 10. P's wishes and feelings; 11. P's views, beliefs and values. 12. But regard is to be had to circumstances from the past only so far as it is still appropriate to have regard to them.
Case E	P is – (a) within the scope of the Mental Health Act, but (b) not subject to any of the mental health regimes	**5 P objects to being a mental health patient etc** 1. This paragraph applies in cases D and E. 2. P is ineligible if the following conditions are met. 3. The first condition is that the relevant instrument authorises P to be a mental health patient. 4. The second condition is that P objects— a. to being a mental health patient, or b. to being given some or all of the mental health treatment. 5. The third condition is that a donee or deputy has not made a valid decision to consent to each matter to which P objects. 6. In determining whether or not P objects to something, regard must be had to all the circumstances (so far as they are reasonably ascertainable), including the following: a. P's behaviour; b. P's wishes and feelings; c. P's views, beliefs and values. d. But regard is to be had to circumstances from the past only so far as it is still appropriate to have regard to them.

1.5.3 Cases A-D are straightforward. Case E is the most complex because it requires consideration of whether an application could be made for detention in hospital for treatment of a 'mental disorder' under the MHA.

1.5.4 Sch.1A is written in technical, language but it is explained in the CoP (paras. 4.40-4.51). However, the explanation is provided in the guidance for Eligibility Assessors. The importance of eligibility is raised in Annex 2 of the CoP (*What should a managing authority consider before applying for authorisation of deprivation of liberty?)* but is not explained there. Informal discussions with psychiatrists prior to the study suggested that, at least when the MCA-DoLS were first introduced, the eligibility guidance was poorly understood, and there was a strong belief that it was indeed possible for practitioners to 'pick and choose between the two statutory regimes as they think fit' (*GJ v The Foundation Trust*[28]).

1.5.5 The ruling in *GJ*[29] provided valuable guidance about eligibility. We have summarised our understanding of the judgement in the top part of Fig. 1.4, as a series of 'filters'. From Case E, it appears that the MHA has 'primacy', *providing* that the criteria for s.2 or s.3 are met. As para. 13.11 of the MCA Code of Practice[30] states: *'(i)f a clinician believes that they can safely assess or treat a person under the MCA, they do not need to consider using the MHA. In this situation, it would be difficult to meet the requirements of the MHA anyway*'. Whether or not an alternative solution is available under the MCA and the criteria for the MHA are really met is the crucial question.

1.5.6 In discussions with practitioners during the development of the study, we found that the judgment was very well-known, and seen as providing a reassuring level of certainty. This may reflect (i) the clarity it provides about the 'primacy' of the MHA; (ii) its relevance to clinicians and others in both psychiatric and general hospitals because it relates to patients who may have both a mental disorder *and* a physical disorder that is not connected to their mental disorder; and (iii) limited relevant additional case law.

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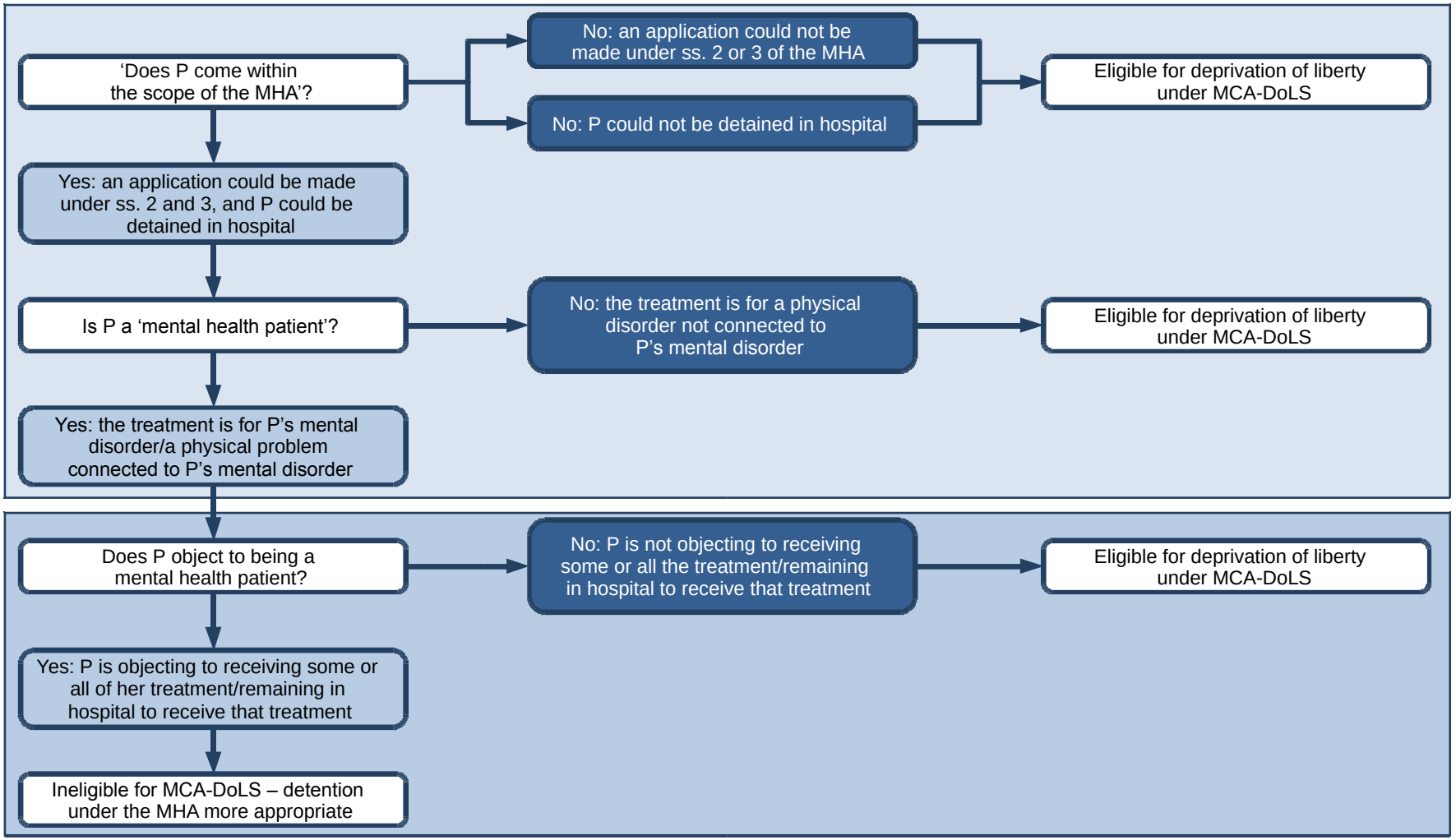
28 *GJ v The Foundation Trust* [2009] *EWHC 2972,* para. 59.
29 *GJ v The Foundation Trust, ibid.*
30 Department for Constitutional Affairs (2007). *Mental Capacity Act 2005 Code of Practice*. London: The Stationery Office.

Figure 1.4: The MCA-DoLS and the MHA interface: *GJ v The Foundation Trust*[31]



[31] *GJ v The Foundation Trust, op. cit.,* n. 28.

1.5.7 Nevertheless, uncertainties for practitioners remain. First, while the meaning of a 'mental health patient' is defined in Sch.1A., its interpretation is not straightforward. There is particular room for confusion among clinicians in psychiatric hospitals, where the definition of 'medical treatment' under the MHA is very broad and includes nursing care as well as the prescribing of medication and other specialist treatment (for example, ECT, psychological treatments), prescribed and carried out by medical practitioners and other members of the clinical team. Secondly, since it was established that *GJ*[32] was not a 'mental health patient', the complex issue of 'objection' (see bottom part of Fig. 1.4) did not need to be considered.

1.5.8 *Objection*: The second part of Case E (see Table 1.2) relates to objection. The concept presents two challenges. First, the role of objection depends on both the treatment and the setting. In broad terms (and with some caveats), the MCA-DoLS cannot be used to deprive a patient of his or her liberty in a psychiatric hospital in order to provide treatment for a mental disorder if that person objects to some or all elements of what is proposed; treatment must take place under the MHA. In contrast, even when someone objects to the arrangements for, or treatment for, a physical disorder in a general hospital or to any kind of care and treatment in a care home, the MCA-DoLS may be used[33]. As far as we are aware, little attention has been paid to the implications of these different approaches towards patients receiving treatment in hospital for physical and mental disorders.

1.5.9 Secondly, there have been concerns about the interpretation and significance of objection. In preparing for the study, some clinicians in psychiatric hospitals expressed the view to us that, unless there was a valid advance refusal in place, patients could not object to remaining in hospital for treatment of a mental disorder because they lacked the capacity to do so; in fact, however, capacity is irrelevant. Two other concerns have been noted, relating to situations where (i) attempts are made to reduce or overcome the person's objection by the use of medication, deception, or the use of threats or force; and (ii) objections to the person remaining in hospital or a care home are made by carers who live with, or are closely involved with, him or her.

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[32] *GJ v The Foundation Trust, ibid.*

[33] See letter from the Department of Health to the tribunal, preceding the decision in *DN v Northumberland Tyne and Wear NHS Foundation Trust* [2011] UKUT 327 (AAC); quoted in Jones, 2012, *op. cit.*, n. 20, p. 294-296.

1.5.10 Most of the guidance about objection in the CoP (CoP, paras. 2.13 and 4.45-4.48), and in the Code of Practice for the MHA (para. 4.19)[34] focusses on general principles. For example, the MHA Code of Practice states that whether or not a patient is objecting '*has to be considered in the round, taking into account all the circumstances, so far as they are reasonably ascertainable. The decision to be made is whether the patient objects to treatment – the reasonableness of that objection is not the issue*' (para. 4.19)[35]. Mention is also made of the need, in making a decision about a patient's objection, to consider the patient's behaviour, wishes, feelings, beliefs, and values, so far as they can be ascertained. Only in para. 2.13 of the CoP is there mention of a possible indicator of objection, the use of restraint.

1.5.11 Some guidance that may be of value to clinical teams in Managing Authorities has been provided by McKillop and his colleagues[36]. They suggest that an objective assessment, through observation of the person's behaviour, be carried out over a period of time. This suggestion tries to address the issue of 'fluctuating objection', where someone appears on some occasions to express a strong objection to remaining in hospital for treatment and other times ambivalence or acceptance. Whether or not this guidance has been widely disseminated is, however, uncertain.

1.5.12 Case law that is relevant to the two situations has been also been developed and informs some of the guidelines about the interpretation of a deprivation of liberty provided by, for example, Jones (2012[37]).

1.5.13 In discussions informing the development of this study, clinicians providing mental health treatment in hospital reported that, prior to the guidance provided by the *GJ*[38] judgment, they felt that their decisions about which of the two statutory frameworks to apply depended, in part, on the nature of the patient. Their *perception* was that the MHA was preferable for younger patients receiving treatment for a mental disorder because of: (i) the protections relating to treatment under Part IV; (ii) a more robust review process; and (iii) the availability of aftercare (under s. 117).

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34 Department of Health (2008). *Code of Practice Mental Health Act. Published pursuant to section 118 of the Act.* London: The Stationery Office.

35 Department of Health (2008), *ibid.*

36 McKillop, M., Dawson, J., & Szmukler, G. (2011). The concept of objection under the DOLS regime. *Journal of Mental Health Law, Spring*, pp. 61-73.

37 Jones (2012), *op. cit.*, n. 20.

38 *GJ v The Foundation Trust, op. cit.,* n. 28.

1.5.14 *Deprivation of liberty*: Whether at the level of Managing Authorities or Supervisory Bodies, the main focus of concern expressed in informal discussions was the concept of a deprivation of liberty. This concept made its first appearance domestically in the case of *HL v United Kingdom*[39] but was only formally introduced into English mental health law by the introduction of the MCA-DoLS. The concept is not new but arises from Art. 5 of the European Convention on Human Rights, with which English law must be compatible. Art. 5 affirms the right to liberty (normally interpreted in its classic sense, as physical liberty[40]); this is absolute, but not unlimited. Among the groups who may lawfully be deprived of their liberty are people of 'unsound mind', such as those with a 'mental disorder'.

1.5.15 A deprivation of liberty may be lawful, but there may still be breaches of Art. 5. Deprivations of liberty must not be arbitrary. As the decision in *HL*[41] illustrated, such deprivations are required to (a) be carried out 'in accordance with a procedure prescribed by law' (Art. 5 (1), and (b) provide an effective means of appeal, so that the detained person has access to a court with powers that (i) allow a speedy decision to be made about the lawfulness of the detention, and (ii) order release if the detention is found to be unlawful (Art. 5 (4)). It was the breaches of these provisions in *HL*[42], an informal patient who could not consent to, but was not deemed to object to, his detention in a psychiatric hospital that resulted in the development of the MCA-DoLS.

1.5.16 From the perspective of a clinical team, the MHA is used primarily for 'the reduction of risks flowing from mental disorder, both to the patient and to others'[43]. Little thought is given as to whether or not a particular individual's detention constitutes a restriction or a deprivation of liberty. To the consternation of practitioners there is no definition of a deprivation of liberty[44,45,46]; nor can there be. It is, instead, a concept that is continuing to evolve in both European and domestic case law. A deprivation of liberty, which is not permitted under the unamended MCA, differs from a restriction, which is (under s. 6), but, as is acknowledged, the distinction is not easily made. The difference between the two is 'merely one of degree or intensity, and not one of nature or substance…[t]he

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39 *HL v The United Kingdom, op. cit.,* n. 14.
40 Allen, N. (2009). Restricting movement or depriving liberty. *Journal of Mental Health Law*, *Spring,* pp.19- 32.
41 *HL v The United Kingdom, op. cit.,* n. 14.
42 *HL v The United Kingdom, ibid.*
43 Richardson (2010), p.2,*op. cit.*, n. 17.
44 Department of Health (2005). *"Bournewood" Consultation: the approach to be taken in response to the judgement of the European Court of Human Rights in the "Bournewood" case*. London: Department of Health.
45 Department of Health. (2006). *Protecting the Vulnerable: the "Bournewood Consultation*. London: Department of Health.
46 Jones (2011), *op. cit*., n. 19.

process of classification into one or other of these categories sometimes proves to be no easy task' (*Guzzardi v Italy*[47]; applied in *JE v DE and Surrey County Council*[48]), and both the European Court of Human Rights and the High Court have sometimes found that onerous restrictions do not constitute a deprivation of liberty.

1.5.17 Guidance about the meaning of a deprivation of liberty and how it may be distinguished from a restriction has been provided by the case law, which is both fast-developing and, occasionally, inconsistent. While the CoP proposes that 'healthcare and social care staff need to keep themselves informed of legal developments that may have a bearing on their practice' (Introduction to Ch. 2), this is unrealistic. It is certainly the case that the approach taken by the courts is broadly similar in that confinement must be established and that the person must not be 'free to leave'. Within the framework of this approach, however, it has been reiterated in case law that the starting-point in considering whether or not there is a deprivation is the individual's 'concrete situation' (Munby LJ in *Cheshire West and Chester Council and Central v P*[49]), taking full account of his or her circumstances. No single 'circumstance' or factor can be considered determinative.

1.5.18 To assist clinical teams and others, the CoP (para. 2.5) tries to translate the available legal judgements into accessible guidance in the form of a list of factors that may be relevant in making a decision as to whether or not a particular person's situation is, or is likely to constitute, a deprivation of liberty. The list comprises seven factors, as follows:

- 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.

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47 *Guzzardi v Italy* (1980) 3 E.H.R.R. 33, para.93..
48 *JE v DE and Surrey County Council* [2006] EWHC 3459 (Fam).
49 *Cheshire West and Chester Council and Central v P* [2011] EWCA Civ. 1257, para.102.

- 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.

1.5.19 This list draws on the judgments (paras. 2.21-2.23) available at the time of the CoP's publication, in 2008. The extent to which it has become out-dated is illustrated by Jones[50]. Drawing on an analysis of the case law up to the end of March 2012, he proposes ten factors that *may* suggest a deprivation of liberty, and fourteen that, of themselves, probably would not. The extent to which these guidelines, which are updated almost annually, are known about by clinical teams in Managing Authorities, or by Best Interests Assessors, carrying out assessments on behalf of Supervisory Bodies, and their status in terms of providing an authoritative, though not definitive, basis for decision-making, is unknown.

1.5.20 In response to changes in the case law, the Department of Health sometimes issues guidance, as an update to the Code of Practice. One such example followed a Court of Appeal judgment (*P (otherwise known as MIG) and Q (otherwise known as MEG)v Surrey County Council*[51]) in which the importance of taking into account the 'normality' of an individual's environment in decisions about possible deprivations of liberty. The guidance suggested that, compared with other settings, including general hospitals: *'(m)ental health settings are different...(t)hey will need to demonstrate that the regime for those not detained under the Mental Health Act (MHA) is distinct and different to the regime for those detained under the MHA. Otherwise, a person who lacks capacity to consent for himself, even when they are not objecting is likely to be deprived of his liberty by simply being in that setting. The Deprivation of Liberty Safeguards will need to be applied in those circumstances even when the person is not objecting if the deprivation of liberty in their best interests is to be made lawful'*[52]*.*

1.5.21 Since, in routine psychiatric care, detained and informal patients usually share the same ward, this guidance has important implications. For clinical teams and Managing Authorities, it suggests that applications for an authorisation under the MCA-DoLS should be made for all informal patients who lack capacity to consent to their

50 Jones (2012), pp. 267-269,, *op. cit.*, n. 20.
51 *P and Q v Surrey County Council* [2011] EWCA 190.
52 Department of Health (2011). *Mental Capacity Act Deprivation of Liberty Safeguards. Summary of two cases on the meaning of deprivation of liberty: the "MIG and MEG" case and the "A and C" case. Gateway reference: 15723.* London: Department of Health.

admission to hospital; for Best Interests Assessors, that all such patients are deprived of their liberty. The status of this guidance in regulating clinical and assessment practice is, however, uncertain. Indeed, whether the approach - prioritising a single factor in the individual's 'concrete situation' - finds legal support remains to be seen.

1.5.22 Arguably, practitioners involved in decisions that are of such importance in safeguarding the human rights of vulnerable patients should seek advice from mental health lawyers. Such advice is available in many NHS Trusts, particularly those that focus on mental health, and to PCTs. Discouragingly, Cairns and her colleagues[53] found that the level of agreement among six very experienced mental health lawyers, presented with the same vignettes providing information about patients with different mental health needs and asked to identify those who might be deprived of their liberty, was no better than chance. These findings provide a striking demonstration of the challenges that practitioners face.

1.6 Summary

1.6.1 The interface between the MCA-DoLS and MHA for limiting the physical freedom of patients requiring treatment for a mental disorder involves decisions between two different legal frameworks. The challenges of the interface reflect, in part, a broader set of challenges arising in the context of the MCA-DoLS: the requirement to translate and apply in clinical practice complex and evolving legal concepts. The task for decision-makers is not made easier by disparate sources of guidance and a Code of Practice for the MCA-DoLS that is now out of date. During informal discussions prior to the start of our study, practitioners seemed to welcome the guidance provided by the *GJ* judgement.

1.6.2 The first objective of this study is to investigate practitioners' understanding of the interface between the MCA-DoLS and the MHA. For this part, we focus exclusively on the application and authorisation process in the MCA-DoLS procedure. In carrying out the second aim, that of considering the effects on patients of the interface, we examine additional aspects of the procedure. Chapter 2 comprises a description of the methods used to carry out these two objectives.

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[53] Cairns, R., Brown, P., Grant-Peterkin, H., Khondoker, M. R., Owen, G. S., Richardson, G., Szmukler, G., & Hotopf, M. (2011). Judgements about deprivation of liberty made by various professionals: comparison study. *The Psychiatrist, 35*(9), 344-349.

CHAPTER 2: METHODS AND DATA COLLECTION

2.1 Introduction

2.1.1 In order to meet the study objectives, as set out in Chapter 1, we adopted an approach that used both qualitative and quantitative data from a number of different sources. In this Chapter, we provide an overview of the methods used, the challenges of data collection, and the information on which the findings we present are based.

2.2 Ethical approval

2.2.1 Research Ethics Committee approval for the research was provided by the Cambridgeshire 3 Research Ethics Committee (reference: 10/H0306/64).

2.3 Support from Supervisory Bodies

2.3.1 The research could not have taken place without the involvement and support of the Supervisory Bodies. Three Supervisory Bodies, with differing rates of Primary Care Trust (PCT) applications and authorisations in both 2009-2010 and 2010-2011, agreed to take part and remained committed to the study throughout. They were based in different areas of the country: SB 1 covers a mixed urban and rural county with a predominantly White British population of approx. 789,700; SB 2 covers a metropolitan borough, with a population of approx. 284,500, from a range of ethnic backgrounds including significant proportions of inhabitants from Black British or Black African backgrounds; SB 3 covers a mixed urban and rural area with a population of approx. 687,300. This population, like that of SB2, is also ethnically diverse, with a significant proportion of residents from a South Asian background.

2.4 NHS Involvement

2.4.1 At the time of the study, most hospitals were commissioned locally by PCTs. After gaining research ethical approval, we sought R & D approval from eleven separate NHS Trusts, across the three SB areas, providing treatment in hospital for physical or mental disorders. With the exception of the Trust in which members of the research team are clinicians, this was challenging and time-consuming; it would have been impossible without the support of colleagues in the Mental Health Research Network.

As far as we could ascertain, the many delays in considering and granting approval for the study to proceed were related to concerns about the demands that the study might impose on Trust resources and/or on patients for whom applications for the MCA-DoLS has been made and, in some cases authorised, and their carers. Even when R & D approval was gained, it remained difficult to identify supportive local collaborators and/or we had to wait until willing collaborators had fulfilled their Trust's training requirements.

2.4.2 These delays limited our opportunities to interview representatives of Managing Authorities responsible for MCA-DoLS applications within the PCTs. While the study focussed on practitioners, the delays also restricted severely our efforts to seek the Managing Authorities' assistance in approaching patients for whom applications had been made and/or authorised. In an attempt to address this matter, we sent, through Supervisory Bodies, invitation letters to patients on whose behalf applications had been made and family or friends who were involved in the MCA-DoLS as Relevant Person's Representatives (RPRs; see Fig. 1.2). Unfortunately, this secondary recruitment strategy was not successful. We do not know how many of our letters of invitation were sent out, but we received no expressions of interest in taking part in the study. .One RPR contacted us independently, and was included. While we were able to address our terms of reference by interviewing a diverse range of relevantly qualified practitioners across the participating PCTs, our examination of the interface between the MCA-DoLS and the MHA is necessarily limited by the absence of insights into the experiences of men and women who were or had been subject to the MCA-DoLS or on whose behalf an application had been made, and, with a single exception, their representatives .

2.5 Sources of information

2.5.1 *Standardised data from the Health and Social Care Information Centre (formally the NHS Information Centre for Health and Social Care)*: Supervisory Bodies are required to provide information relating to applications for authorisations under the MCA-DoLS and reviews (while it is not relevant in the present context, they are also required to provide information on the *number* (*no* other details) of individuals subject to the MCA-DOLS on particular 'census' days). This information is collected by what was previously the NHS Information Centre for Health and Social Care (NHSIC) and is now the Health and Social Care Information Centre (HSCIC) as part of the national MCA database. With the exception of the 'census' count, the MCA data are based on

aggregated, or summary, information about the number of applications made and authorised, not the number of individuals to whom they apply. By contrast, in the primary MHA dataset (the MHMDS) each patient has a unique identifier. This allows `Mental Health Care Spells' relating to individual patients to be linked (a 'spell' is a 'continuous period of care or assessment for an adult'[54]). Where feasible, we used these two databases, supplemented with additional data from the MHMDS that are normally restricted, but which we were able to obtain, to compare and contrast the characteristics and experiences of groups of patients who were subject to the MCA DoLS or detained under the MHA (see Chapter 3; a technical section can be found in Appendix II).

2.5.2 *Application and Assessment Forms*: We asked the Supervisory Bodies to provide us with anonymised completed copies of the Department of Health's versions of *Form 4* (Request for Standard Authorisation) and *Form 10* (Best Interests Assessment) relating to individuals in services commissioned by PCTs. SBs 1 and 2 were asked to provide consecutive Forms, starting from 1st April, 2009; SB3, which received many applications, was asked to select one in three. The task of anonymising and copying the forms was demanding for the SBs but we were provided with 37 pairs of *Form 4s* and *Form 10s* relating to 30 separate individuals (for seven people, more than one application was made) in services commissioned by PCTs. The characteristics of these thirty individuals are provided in Table 2.1.

Table 2.1: Summary of characteristics of individuals (n=30) for whom one or more applications was made for the MCA-DoLS.

Individual characteristics	**Gender:**	Female	12
		Male	18
	Age:	65 years or older	16
		18-64 years	14
	Ethnicity:	White British	27
		Asian/Asian British	0
		Black/Black British	3
	Primary disability:	Dementia	15
		Learning disability	4
		Other	11

[54] Health and Social Care Information Centre (2008a). *Mental health bulletin. First report and experimental statistics from Mental Health Minimum Dataset (MHMDS) annual returns, 2003-2007*. Leeds: The Health and Social Care Information Centre, Mental Health and Community Care Team. Available at: https://catalogue.ic.nhs.uk/publications/mental-health/services/ment-heal-bull/ment-heal-bull-rep-v1.pdf.

2.5.3 The Forms were analysed through close reading and discussion with the study team, with additional advice from members of the Advisory Group. Of these, twenty-six applications (relating to twenty different individuals) were subsequently authorised. We used these data to supplement information from the national MCA database.

2.5.4 Two additional completed *Form 10*s were passed to the study team at a later date and were analysed in the same way. The 39 *Form 10s* related to a broad range of individuals: patients receiving treatment for physical disorders in general hospitals (20), some of whom had clinical diagnoses including dementia (7) learning (intellectual) disability (1), HIV/AIDS (1), or brain injury (2); patients in psychiatric hospitals (18), among whom were men and women in designated facilities for people with dementia (8) or learning disabilities and additional mental health and/behavioural needs (2); and specialist respite provision for people with learning disabilities and these additional needs (1).

2.5.5 Finally, we looked carefully at the wording of the Department of Health's versions of *Forms 5* (the Age Assessment, *6* (the Eligibility Assessment), *7* (the Capacity Assessment), and *9* (the Eligibility Assessment). Copies of *Forms 4*, *5*, *6*, *7*, *9*, and *10* are provided in Appendices IIIa) – f).

2.5.6 *Interviews*: Through the involvement of the three Supervisory Bodies, we carried out semi-structured interviews with individuals with at least one role within the application and authorisation process to investigate their understanding and experiences of working at the MCA-DoLS interface. Interviews were also held with senior representatives of the three participating Supervisory Bodies, Mental Health Assessors; Best Interests Assessors, an Independent Mental Capacity Advocate, and a Managing Authority (see Table 2.2, below).

2.5.7 As we gained a better understanding of the differences between the operation of the MCA-DoLS in the different Supervisory Body areas, we learned that there was an additional role, that of 'Advisers', who could be based at specific psychiatric or general hospitals, within Trusts, or with Supervisory Bodies. These individuals supported Managing Authorities in making decisions about whether or not to make an MCA-DoLS application and/or screened applications to ensure that the necessary forms were properly completed and were appropriate before they were submitted to the relevant Supervisory Body. We also carried out interviews with a few individuals who were not

based in one of our participating Supervisory Bodies, including a parent who was a Relevant Person's Representative.

2.5.8 Wherever possible, the interviews took place face-to-face, and the responses were audio-recorded and transcribed; detailed notes were kept of telephone interviews. The written records were examined for content with emergent themes identified and coded[55]. The codes and the subsequent analysis were refined and validated through meetings of the research team and the Advisory Group.

2.5.9 *Vignettes*: Four brief vignettes, presenting clinical cases, were designed (see Table 4.1) and presented to participants (see Table 2.2, below) through professional development events, study interviews, or through a website to examine whether they would use the MCA-DoLS, the MHA, or a different legal framework, and the reasons for their decisions. These vignettes are shown in Chapter 3, Table 3.1.

Table 2.2: Interview and vignette samples

		Interviews	Vignettes
		Number of participants	Number of participants
Primary role(s)	Best Interests Assessor	3	9
	Best Interests/Eligibility Assessor	4	5
	Mental Health/Eligibility Assessor	5	7
	Managing Authority	1	-
	MCA-DoLS Adviser	5	-
	Supervisory Body Representative	3	3
	Independent Mental Capacity Advocate	5	1
	Relevant Person's Representative	1	-
	MCA-DoLS Trainer	1	2
	Specialist Social Worker	1	-
	Trainee or Consultant Psychiatrists	-	67
	Total	**29**	**94**

Not all the responses of the participants are reported; the remainder have been used as additional material to inform the analysis.

2.5.10 *Additional information*: Further insights into practitioners' understanding of the MCA-DoLS, focussing on the interface with the MHA, were sought by:

[55] Cicourel, A. V. (1964). *Method and Measurement in Sociology*. New York: Free Press of Glencoe.

a) establishing an Advisory Group (see Appendix I for a list of members), which met quarterly from the start of, and throughout, the study;
b) participant observations during 2010 and 2011 at local and national events involving different groups of clinicians and/or different role holders in the MCA-DoLS application and/or authorisation process;
c) organising a national Dissemination and Consultation Event in London on 21st November, 2011. Notes were taken of the discussions to clarify, supplement, and validate data from other sources, and we received some additional material, such as local policies, from the participants. As the analysis of the data progressed, informal discussions were held with some of the participants in the event, as well as representatives of the Supervisory Bodies in the three study areas, to check issues relating to the emergent themes.

2.6 Summary

2.6.1 The methodology used to address the terms of reference is described in detail. A mixed-methods approach, comprising the collection of both qualitative and quantitative data, was used. The challenges, particularly in obtaining support from NHS Trusts, are highlighted.

2.6.2 In the next two Chapters, the qualitative and then the quantitative findings are presented and discussed.

CHAPTER 3: PRACTITIONERS' UNDERSTANDING OF THE INTERFACE BETWEEN THE MCA-DOLS AND THE MHA

3.1 Introduction

3.1.1 The number of applications for the MCA-DoLS is rather fewer than was expected, albeit on the basis of very limited evidence[56,57,58]. These low numbers may, in part, reflect practitioners' understanding of the interface between the MCA-DoLS and the MHA, as well as their broader understanding of the procedure and its interface with the 'parent' legislation - the MCA - and with the common law framework for treatment in hospital of a mental disorder.

3.1.2 In this Chapter, we examine practitioners' understanding through the prism of their decision-making, not only at critical points, where there may be, or appear to be, a choice of two frameworks for civil detention, but also through their responses to the text in some of the standard Forms (see Table 1.1) used in the application and assessment process.

3.1.3 To carry out the task, we draw on a diverse range of data: information from formal interviews, vignettes, an analysis of *Forms 4* (the Request for a Standard Authorisation) and *10* (the Best Interests Assessment), reviews of the text boxes of other Forms, and discussions that took place with clinicians and other practitioners.

3.1.4 Practitioners' understanding of the MCA-DoLS and MHA interface arises in a context. Before we examine their decision-making, we discuss some broad issues that inform this context.

3.2 Some support for the MCA-DoLS

3.2.1 Given the widespread dissemination of criticism of the MCA-DoLS[59,60,61,62,63,64] and the concerns that we heard during the development of the study, it is, perhaps, surprising

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56 Care Quality Commission (2012), *op. cit.*, n. 1.
57 Department of Health (2005), o*p. cit.*, n. 44.
58 *Mental Capacity Act 2005, Deprivation of Liberty Safeguards Assessments (England) – First report on annual data, 2009/10*. Leeds: The Health and Social Care Information Centre. Available at: http://www.hscic.gov.uk/pubs/mentalcapacity0910
59 Cairns et al. (2011), *op. cit.*, n. 53.
60 Care Quality Commission (2012), *op. cit.*, n. 1.

that some practitioners expressed such a high level of support for the regulations. These positive views appeared, in part, to reflect the belief that the introduction of the MCA-DoLS would improve understanding of, and compliance with, the principles of the parent legislation (the MCA) by (i) highlighting the importance of acting in the 'best interests' of any adult who lacks capacity and on whose behalf a decision needs to be made; and, relatedly (ii) promoting a person-centred approach to the care and treatment of vulnerable men and women.

3.2.2 In addition, however, there was some support for the MCA-DoLS procedure itself. In particular, positive mention was made of the opportunities its provides for (i) the consideration of less restrictive alternatives in making arrangements for a person's care and treatment; (ii) the imposition of conditions, which, even though a deprivation of liberty has been authorised, might still lead to improvements in the person's quality of life; (iii) independent scrutiny through the authorisation process and reviews; (iv) the involvement of Relevant Person's Representatives (normally, family or friends of the person) or an Independent Mental Capacity Advocate; and (v) the right to challenge decisions, ultimately through the Court of Protection. Together, these measures were thought to provide potentially powerful protections for the human rights of a group of men and women who, too often, suffer neglect or other forms of abuse.

> 100%, lots and lots of benefits...because of that process… less restrictive alternatives are put in force, even [*when they*[65]] still amount to a Deprivation. There's the review process and also the RPR [*Relevant Person's Representative*], certainly for people that have no friends or family, it was only once they got a DoLS Authorisation in place and appointed a paid RPR, it was only then that they had somebody regularly visiting them who wasn't working for the managing authority...There are lots of benefits really… I think it really improves people's quality of life, and the options and opportunities that people are being offered and being given as well…
>
> Independent Mental Capacity Advocate (IMCA), Interview

> I think the fact that if someone is in hospital being deprived of their liberty, I think there's a definite benefit in that [*the*] person will not stay in a hospital…without having some kind of independent review. So that's a definite plus in terms of a safeguard….I think some of the conditions that are attached by BIAs [*Best Interests Assessors*] benefit the

61 Jones (2011), *op. cit*., n. 19.
62 Jones (2012), *op. cit*., n. 20.
63 Hargreaves (2011), *op. cit*., n. 21.
64 Szerletics & O'Shea (2011), *op. cit*., n. 22.
65 All the excerpts in this chapter are verbatim, except when italics are used in square brackets to maintain anonymity or clarify meaning.

> patient…[*and*] has worked really well in heightening people's awareness around capacity issues because it's pushed it right to the forefront.
>
> 'Adviser', interview
>
> There is now a process in law... there has to be a proper best interest decision making process and…least restrictive option and they can get a representative and can go to court: a) It improves the standards if practice; b) It gives people rights to protest against it.
>
> Best Interests Assessor, interview

3.2.3 Unfortunately, even among the 'early adopters' who had engaged with the MCA-DoLS soon after their introduction, and agreed to participate in our study, such positive views were *not* common. Moreover, they were overwhelmingly expressed by those in roles that were either strongly linked to the MCA and/or to the MCA-DoLS. It did not seem, however, that these positive views simply reflected ignorance of the MHA. Best Interests Assessors who were also Approved Mental Health Practitioners (AHMPs) and therefore had expertise and experience in working with the MHA were not less positive than their counterparts who did not have this dual training. The suggestion is that positive opinions about the MCA-DoLS procedure may reflect familiarity with, and support for, the principles of the Mental Capacity Act.

3.2.4 Amongst the medical practitioners all of whom, in our study, were psychiatrists, and whose clinical practice and experience was therefore based within the framework of the MHA, there appeared to be more ambivalence.

> There is a lack of consensus between different professional groups about 'least restrictive' options. Superficially, MCA seems least restrictive but I would argue as there are fewer rights for the person detained. In fact the MHA is probably less restrictive...I must say I have found DoLS completely unhelpful and my personal view is that it could simply be abandoned without anyone being any worse off.
>
> Consultant psychiatrist, Dissemination and Consultation Event

In some cases, such views were held even by medical practitioners who had taken on roles in the MCA-DoLS procedure.

> I can see that it would have its advantages in certain cases. But generally I think it's an unnecessary piece of bureaucratic exercise, really…
>
> Mental Health Assessor, interview

3.2.5 Moreover, even among the most enthusiastic proponents of the MCA-DoLS, there were concerns.

3.3 Concerns about the MCA-DoLS

3.3.1 Concerns about the MCA-DoLS coalesced around three main themes: (i) uncertainty about the meaning of a 'deprivation of liberty; b) the demands of the procedure; and c) the absence of clarity about the status of the available guidance.

3.3.2 *Uncertainty about the meaning of a 'deprivation of liberty*: As we expected from our pilot work, there was concern about the meaning of a deprivation of liberty. While apparently acknowledging fully that it was, ultimately, for a Court to decide in the circumstances of the particular case, there was widespread agreement that the absence of a precise definition severely compromised the credibility and effectiveness of the MCA-DoLS. Perhaps not surprisingly, given their roles in deciding whether or not an individual may be, or is, at risk of a deprivation of liberty, these concerns were expressed most strongly by Managing Authorities, Best Interests Assessors, and representatives of Supervisory Bodies. No mention was made of the possible opportunities that the absence of a definition might present in terms of developing 'good practice'.

3.3.3 Instead, representatives of Supervisory Bodies, in particular, reported that they attempted to respond to their feelings of uncertainty by keeping abreast of developments in the case law. It was felt by at least one such practitioner, however, that this was a dispiriting pursuit of an illusion and there was considerable concern that, at the margins, decisions about what constituted a deprivation of liberty could be idiosyncratic and arbitrary[66]. For these representatives of Supervisory Bodies, and also for Best Interests Assessors, such uncertainly was reported as a source of considerable stress.

> The complication is the defining of what constitutes DoLS… On the one hand, we say that DoLS can't be defined; only the courts can define what a DoLS is and yet we're asking these people [*Best Interests Assessors*] to go out once we get a referral, to act as a court to decide, and yet they get criticised if they get it wrong… the improvement will come about if there's more case law that informs what exactly is a DoLS, but again I just don't know if it's possible ever to define what's a deprivation, ever, because it's something so abstract…there are a range of factors that will contribute to our understanding of whether it's a deprivation or not; there's no one fast

[66] Cairns et al. (2011), *op. cit.*, n. 53.

> definite, that's why it's so difficult. Every case we'll have big discussions among ourselves, every case you can argue both ways…DoLS has come about because of arbitrary decision-making; you want to stop people making arbitrary decisions…
>
> Representative of a Supervisory Body, interview

3.3.4 *The demands of the procedure*: A range of concerns was expressed about the procedure itself. This psychiatrist's view was typical:

> … it's very bureaucratic. .. there has to be a way of writing this in clearer English. It seems incredibly bureaucratic and cumbersome really, both from my point of view and also from the point of the charge nurse on the ward… if one really did have to do it for all twenty patients on the ward, there'd be no time for the staff to actually talk to the patients and do the useful things.
>
> Mental Health Assessor, interview

3.3.5 Representatives of Supervisory Bodies expressed similar concerns. First, they reported that it was sometimes difficult to complete all aspects of the procedure within the time constraints laid down in Sch.A1. This was felt to be particularly taxing for Urgent Authorisations, which must be completed within 7 days. Secondly, dissatisfaction was expressed with some of the Forms. There was criticism of those with primarily tick-box formats, such as *Form 7* (the Mental Capacity Assessment, see Appendix IIId) and *Form 9* (the Eligibility Assessment, see Appendix IIIe), because they obscure scrutiny of the basis of the Assessors' decisions. *Form 5* (the Age Assessment), which is used to record information available from other Forms (for example, in Part H of the Best Interests Assessment, Appendix IIIf),was also widely criticised: there was a consensus that it epitomises the excessive and unnecessary bureaucracy that characterises many aspects of the MCA-DoLS procedure.

3.3.6 *Plenty of guidance, but an absence of clarity*: Again, as expected, there was widespread concern about the Code of Practice (CoP)[67]. It was viewed as out-dated and the clarity of the advice it provides was compared unfavourably with that of fthe Code of Practice of the 'parent' legislation[68]. While, in part, concerns about the lack of clarity may reflect the sense of frustration about the absence of a definition of a deprivation of liberty, it was also pointed out that the CoP focuses on the MCA-DoLS in isolation, without any consideration of its interfaces with the MCA or the MHA.

> …the problem is that when…because again, where does the Mental Health Act finish

[67] Ministry of Justice (2008), *op. cit.*, n. 15.
[68] Department for Constitutional Affairs (2007), *op. cit.,* n. 30.

> and the Mental Capacity Act start?...both of them are quite good, but there should be something, Code of Practice for the two together somewhere…
>
> Mental Health Assessor, interview

There were also requests for more guidance on the interfaces between the MHA, the MCA and other relevant policy and legislation, particularly Adult Safeguarding and the Human Rights Act 1998[69]. It was reported that the inclusion of such issues would be very helpful, provided it were accompanied by clinical examples that captured the complexity of the situations encountered by practitioners.

3.3.7 While the three representatives of Supervisory Bodies, in particular, but also many other practitioners were aware of sources of guidance beyond the Code, considerable confusion was expressed about their status and implications. In this context, specific mention was made of the guidance following the ruling in *P and Q*[70] (see Ch. 1.5.20), which was issued by the Department of Health during the course of the study,

3.3.8 This overview of support for and concerns about the MCA-DoLS provides the context for the next sections, in which the initial stages of making an application for, and carrying out the necessary assessments for authorising, a deprivation of liberty are examined in more detail.

3.4 The MCA-DoLS process: applications and assessments[71]

3.4.1 According to the overview of the MCA-DoLS procedure in Annex 1 of the Code of Practice (CoP; shown, with minimal adaptations in Fig. 1.2), the first stage requires the Managing Authority to identify that an individual is, or is likely to be, at risk of a deprivation of his or her liberty and make an application to a Supervisory Body for an authorisation. The receipt of this application prompts the second stage, the commissioning by the Supervisory Body of six assessments by at least two independent assessors. Fig. 3.1 illustrates which practitioners can carry out the assessments. All six must support the application in order for an authorisation to be granted.

3.4.2 In services that are registered for the use of the Mental Health Act, a decision may be made, in accordance with the procedure set out in the MHA, that someone fulfils the criteria for detention in hospital for assessment and/or treatment of a 'mental disorder'.

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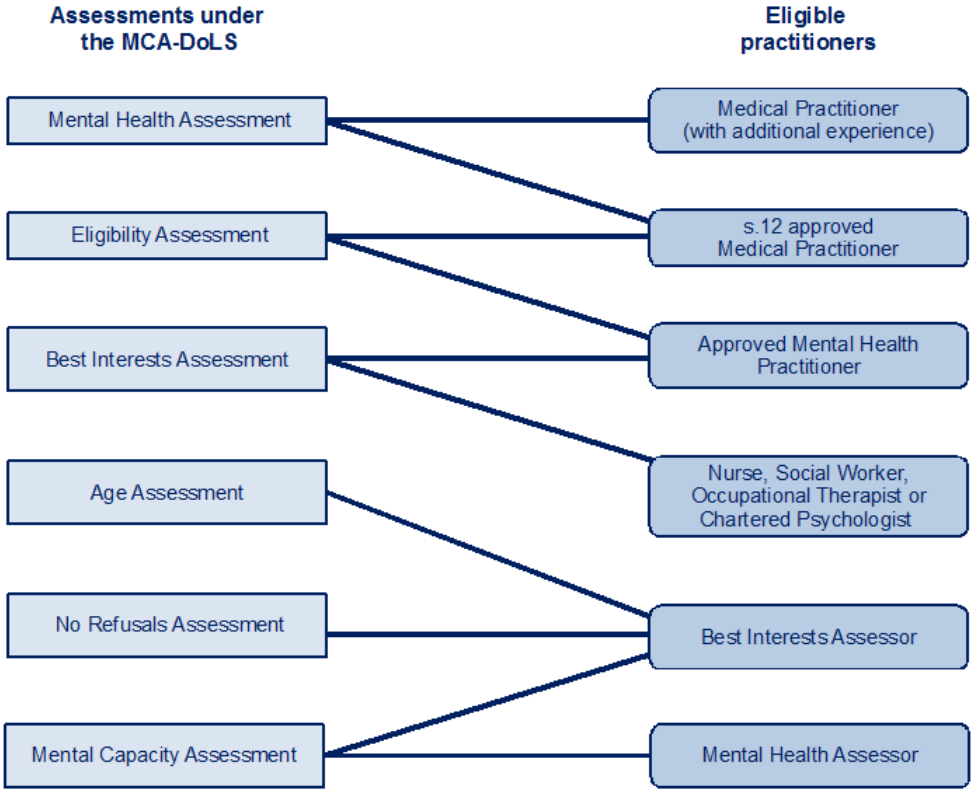
69 *Human Rights Act 1998*. London: The Stationery Office.
70 *P and Q v Surrey County Council* [2011], *op. cit.*, n. 51.
71 A full account is provided in Sch. A1 of the Mental Capacity Act 2005.

While there are situations in which the MCA-DoLS and the MHA *can* both be used for an individual with 'just' a mental disorder who objects to remaining in hospital for some or all the treatment, the two legal frameworks are normally mutually exclusive. If a patient is identified as requiring the MHA, an application for the MCA-DoLS will not normally be made.

Figure 3.1: Eligibility requirements for carrying out assessments (adapted from Ch. 4, CoP)



3.4.3 In the following sections, practitioners' understanding of the MCA-DoLS is explored. We argue that, perhaps reflecting the complexity of some of the clinico-legal concepts involved, limitations in the documentation, and, at least in some cases, ambivalence about the benefits of the procedure, practitioners apply 'rules of thumb' - simple and easily applied principles that need not be absolutely reliable and accurate. Such 'rules of thumb' are often pragmatic but they can also be problematic.

3.5 Decision-making prior to applications for the MCA-DoLS

3.5.1 In order to examine how practitioners distinguish individuals for whom an application should be made under the MCA-DoLS, and those for whom the MHA is appropriate, we devised four vignettes. These were selected to reflect case law and local clinical

experience, but proved to be representative of the kinds of case described in the anonymised *Forms 4* and *10*. The vignettes are shown as Table 3.1. The focus here is on the responses of the seventy-four psychiatrists (seven Mental Health/Eligibility Assessors; 67 other psychiatrists).

Table 3.1: Vignettes

Ms A

Ms A is a woman with a mild learning disability and schizo-affective disorder. She has lived for most of her life with her parents, but was recently removed from their care following some safeguarding concerns. She is currently a patient at a local psychiatric hospital, and her parents are not permitted to make contact or visit. She is receiving treatment for her schizo-affective disorder and takes her medication without protest. She says she feels happy, but is reluctant to talk about her home or family and normally changes the subject. She has not made any attempts to leave.

Ms A seems to lack the capacity to decide about her care and treatment. There are concerns that she is deprived of her liberty at the hospital. However, there is a disagreement between the clinical team. Ms A's social worker believes that a MCA-DoLS authorisation is the best way forward, but her psychiatrist would prefer to make an application for detention under the Mental Health Act 1983.

Mr B

Mr B is 72 years old, and has a diagnosis of vascular dementia and Korsakoff's Syndrome due to alcohol. He also has diabetes, but is increasingly unable to administer his own insulin effectively, and has had several recent hypoglycaemic attacks. He moved to a care home, but the placement broke down because he often went to the local pub, and when he returned, was unruly and disruptive towards other residents.

Mr B was admitted to a local psychiatric hospital, where he was treated for his diabetes. He was also prescribed medications to assist with his alcohol dependence and to help him sleep.

Mr B seems to lack capacity to decide about his care and treatment. He is objecting to being in hospital, and says that he wishes to return to the care home; however, the care home does not want to accept him. The hospital staff are concerned about his health and safety if he returns to his own home and wish to apply for an MCA-DoLS authorisation. However, Mr B's family would prefer him to be detained under s.3 of the Mental Health Act 1983.

Ms C

Ms C is 60, and has Alzheimer's dementia. She had been detained under s.2 of the Mental

Health Act 1983, but that has recently expired, and her psychiatrist has decided there is no further appropriate treatment.

Ms C lacks capacity to decide where she should live, and is not able to look after herself adequately. Her daughter does not have space in her own home to care for her, and as a result, Ms C needs to be cared for in a residential home. However, the local social care management team has not yet been able to find Ms C a placement at a care home which will take patients with dementia. As a result, Ms C is still on the ward in the hospital where she was previously a detained patient.

Because of the danger that she may get lost or come to harm, Ms C is not permitted to leave the ward, and the doors are kept locked. Ms C is no longer receiving treatment for her dementia and is objecting very strongly to remaining on the ward, demanding to 'go home'.

Mrs D

Mrs D is 68 years old and has depression. She currently lives in a care home and is prescribed anti- depressant medication, which she takes without complaint. However, she has recently begun to refuse food and drink and staff at her care home have become very worried about her health. They have consulted a consultant psychiatrist who has recommended a trial of ECT as a treatment for her increasingly severe depression.

The proposed treatment was explained to Mrs D, who refuses it, saying that everyone would be better off without her. The care home staff are concerned as Mrs D is normally an optimistic and lively person who gets on well with others. They think that her choice to die is out of character and wonder whether she really has the capacity to make this treatment decision for herself.

Mrs D's clinical state continues to deteriorate and an assessment is arranged with a view to her being admitted to hospital for treatment for depression and also to monitor her increasingly fragile physical state. Everyone agrees that she is increasingly unable to understand the treatment that has been recommended and is not able or willing to communicate her views on this matter. As her mental state has deteriorated she has become less resistant to intervention. There is a discussion as to whether treatment is most appropriately given in hospital under the framework of the Mental Capacity Act in her best interests or whether section 3 of the Mental Health Act should be used as, in the past, she has objected to ECT.

The responses are shown in Table 3.2.

Table 3.2: Psychiatrists' choices of legal framework

		Legal framework				
		MHA	MCA-DoLS	MCA	Uncertain	n
Vignettes	Ms A	20%	65%	5%	10%	20
	Mr B	20%	68%	6%	7%	71
	Ms C	9%	74%	14%	2%	43
	Mrs D	93%	0%	2%	6%	54

Notes: a) due to rounding up, the figures may not add up to 100%; b) differences in sample sizes reflect both the number of vignettes presented on each occasion, as well as the number attempted by respondents.

3.5.2 The findings are striking. More than nine in ten of the respondents selected the MHA as the appropriate framework for providing Mrs D with ECT. In contrast, around three-quarters of the respondents selected the MCA-DoLS for Ms C, with around two thirds choosing this legislation for Ms A and Mr B. With the exception of the vignette relating to Ms C, few respondents selected the MCA on its own. Twenty non-medical participants, with different roles in the MCA-DoLS process, also completed the vignettes for Ms A and Mr B. The pattern of their responses was not statistically significantly different, suggesting that the psychiatrists' responses to these two vignettes were not idiosyncratic.

3.5.3 When we examined the responses in more detail, respondents were generally able to present a rationale for their decision. Overwhelmingly, the more experienced psychiatrists (those who identified themselves as Consultants and/or held roles in the MCA-DoLS process) selected the MCA-DoLS for Mr B, demonstrating in their responses that they were aware of and understood the *GJ* judgement[72]. As might be expected, trainees made fewer references to this piece of case law. Encouragingly, almost all the respondents, including some of those who were 'uncertain', demonstrated some evidence of a process of working through different elements. However, perhaps because the instructions to the respondents were not sufficiently clear, the range of options considered was often limited. Nevertheless, a small minority

[72] *GJ v The Foundation Trust, op. cit.,* n. 28. When a patient has a physical and a mental disorder, the decision-maker should ask whether 'but for' the need for him or her to have treatment for his physical disorder, should that patient be detained in hospital? para. 87.

of respondents demonstrated broader reflection on the case: for example, more than one person raised the possibility that Mr B did not need to be in hospital at all.

3.5.4 Interviews and discussions with psychiatrists provided additional insights into the way in which the interface between the MCA-DoLS and the MHA is conceptualised in psychiatric hospitals. These practitioners appeared to begin their decision-making by *ruling out* the use of detention under the MHA. Only then is the MCA-DoLS considered. We heard many times that the rationale was that part of the *GJ* judgement in which Charles J. states that '… the MHA 1983 has primacy…'[73]. In this context, the debate over details of the interpretation of this 'primacy' principle[74] is not the point. Psychiatrists (and others, judging from their responses) seem to be using this case law as a 'rule of thumb' to support decision-making between the MCA-DoLS and the MHA.

3.5.5 This orientation towards the use of the Mental Health Act appears to be consistent with the professional view of most of the psychiatrists we interviewed: if the person requires treatment in hospital for a mental disorder, and fulfils the criteria, the MHA is to be preferred.

> I think the most important thing is, does the person need to be in hospital? I think if the person needs to be in hospital for any sort of treatment, then they should be under the Mental Health Act; when I say hospital I mean psychiatric hospital. But then the second thing is whether the treatment's mainly mental or physical. If it's for physical illnesses, then probably the Mental Capacity Act and DoLS should be used. But that's for long term physical illnesses, and otherwise the Mental Health Act should be used. So I think the main thing is whether the person needs to be in a care home or in hospital. If for any treatment requirement the person needs to be in hospital, then I think I would rather use the Mental Health Act.
>
> Mental Health/Eligibility Assessor, interview

3.5.6 Interviewees' justifications for their views were very similar to those we heard during the development of the research (see Ch. 1.5.12), and coalesced round the same three arguments about the MHA. First, that the criteria for detention and for some treatments are more open and challengeable and therefore provide a level of protection for patients that is viewed as absent from the MCA-DoLS. Secondly, that the procedure for mandatory reviews is considerably more robust. Thirdly, that the

[73] *GJ v The Foundation Trust, op. cit.,* n. 28, para. 59.
[74] Jones (2012), *op. cit*., n. 20, pp. 294-296.

duty to provide aftercare under s. 117 is considered of such benefit to patients that it is to be preferred for anyone who might return home discharge.

3.5.7 Nevertheless, as the responses to the vignettes illustrate, many psychiatrists believed that there was one situation for which the MCA-DoLS could be useful in a psychiatric hospital. This related to individuals who had been detained under the Mental Health Act, no longer met the criteria, but whose discharge to residential accommodation, rather than to their own homes, was now delayed. Their willingness to consider the MCA-DoLS in this situation seemed to reflect their conceptual distinction - which does not form part of the Mental Health Act - between 'active medical treatment' (such as ECT, medication, psychological interventions), 'appropriate' for a mental disorder from which there was a reasonable chance of recovery, and 'care' (support with personal care and/or everyday tasks).

> The two [*MCA-DoLS and MHA*] overlap a little bit, but generally people who don't need any active treatment or any assessment for treatment and the effects of treatment could be under a DoLS.
>
> Mental Health/Eligibility Assessor, interview

3.5.8 The responses to the vignette relating to Mrs D were consistent with this suggestion. Almost all the psychiatrists chose the MHA as the appropriate framework for the provision of ECT in hospital. Conversely, despite information that Ms C objected to being in hospital, the majority dismissed the use of the MHA on the grounds that 'active treatment' had ended and that she would be moving to residential accommodation.

3.5.9 These data suggest that psychiatrists are reluctant to use the MCA-DoLS with men and women who are being treated for a mental disorder except in strictly defined circumstances: when it is viewed as a means to ensure that patients who have previously been detained under the MHA do not come to harm prior to discharge into residential accommodation. There was no mention of its use for authorising deprivations of liberty for other informal patients.

3.5.10 At the end of the project, we asked a small number of psychiatrists to reflect on our findings. They responded that pressures on in-patient beds, at least in general psychiatry, means that men and women who are admitted informally usually fulfil the criteria for the Mental Health Act, but appear to be willing to remain in hospital to receive the proposed treatment. As soon as they are believed to object, they are

detained. Capacity to consent is, apparently, rarely assessed unless treatment under Part IV of the MHA is being considered.

3.6 Decision-making in applications to Supervisory Bodies

3.6.1 The account presented in Ch. 3.5 suggests that applications for the MCA-DoLS on behalf of patients in psychiatric hospitals will not often be made. Yet, according to the first stage of the MCA-DoLS procedure (see Fig, 1.2), Managing Authorities have a legal responsibility to submit an application to the Supervisory Body for patients in general and psychiatric hospitals who lack capacity to make decisions about arrangements for their care and treatment and/or elements of that care and treatment and may be at risk of a deprivation of their liberty.

3.6.2 The Managing Authority's responsibility is discharged by the completion and submission of *Form 4*, the *Request for a Standard Authorisation* (see Appendix IIIa). Importantly, this Form requires Managing Authorities to describe:

- *The purpose of the deprivation for which authorisation is being requested* (Box A7); and
- *Why the person needs to be deprived of his or her liberty* (Box B9)

and requires the Managing Authority (normally, a representative), to distinguish the arrangements for a patient's care and treatment from the care and treatment itself.

3.6.3 An analysis of thirty-seven *Form 4s* relating to thirty men and women in services commissioned by PCTs enabled us to examine the arrangements for the provision of care and treatment that led Managing Authorities to apply for MCA-DoLS authorisations. As we have noted in Chapter 2, the patients for whom a deprivation of liberty was sought had a range of difficulties. The applications fell into two broad categories. First, there were those associated with medical treatment in a general hospital involving patients who (i) lacked capacity and were unable to participate in most of or all the decisions that needed to be made on their behalf; and (ii) were subject to severe restrictions (for example, through the use of mittens or bed rails) to inhibit involuntary movements that might compromise their treatment. Secondly, and more frequently, there were arrangements for patients in either general or psychiatric hospitals who were more active, and usually, mobile. Such patients were normally expressing a wish, or making attempts, to leave and/or were resisting their treatment so forcefully and/or so often that restraint had to be used. No information was provided

that enabled us to know whether these patients had ever been detained under the MHA.

3.6.4 In general, the physical and/or mental health needs of the patients, and their capacity (though this was frequently described, for individuals in psychiatric hospitals, as 'insight') and behaviour (lack of respect for the good order of the ward; threats towards staff; an expressed wish to leave hospital and/or return home) were well-described, as were the details of the care and treatment being provided. However, regardless of the patient's needs or the setting, the Managing Authorities struggled to describe the *purpose* of an application for authorisation of a deprivation of liberty; instead, they reported simply that it was intended to provide the patient with care and treatment. Admittedly, 'purpose' is a complex legal concept, which has been the subject of some debate within the case law[75]. The consequence was though that care and treatment and a deprivation of liberty were conflated. This is illustrated by Table 3.3 taken from Box A7.

Table 3.3: Care and treatment described but not the 'purpose' of a deprivation of liberty

> [[*X*] has ongoing mental health problems (arising secondary to her underlying neurological problems) and presents with aggressive, impulsive behaviour with mood disturbances, memory problems and confusion. She in addition has difficulties in co-ordination and gait (again secondary to underlying physical problems). She also becomes physically aggressive and as well has seizures. She needs constant care and help in an inpatient unit for further treatment of the above and also to prevent further harm to self and others. She is unable to clearly understand, retain and weigh the information given to her to make a decision regarding her treatment and care in the hospital and therefore lacks capacity for the same. She is currently being nursed by the staff in the unit in PICU [*Psychiatric Intensive Care Unit*] setting to prevent harm to herself and others. Needs constant help with activities of daily living (including care of personal hygiene, helping with toilet need etc.). She also needs antipsychotic medications along with the anti-epileptic medications she is already on. She is unable to understand and consent to these at present as she is unable to understand the information given and retain it and make a well informed decision about whether she wants to have the medications or not. It is in her best interests that she continues to get the above care in the inpatient Unit to prevent further deterioration in her mental and physical wellbeing. We have tried to give her the above care in a less restrictive Open psychiatry female ward but then she had to be shifted to the PICU as she started

[75] *Cheshire West and Chester Council and Central v P* [2011], *op. cit.*, n. 49, para. 102.

becoming unmanageable on the open ward and posing a risk to other vulnerable patients on the ward (she was noted to be physically aggressive to a few patients).

3.6.5 It appeared that Managing Authorities were aware of their difficulties in writing about the purpose of the putative deprivation of liberty. Often, B9 contained text that was cut and pasted from Box A7, directed attention back to Box A7, or was simply left blank. One consequence, however, of the sparse completion of Box B9 was that alternative arrangements for delivering care and treatment were rarely explored.

3.6.6 Difficulties in writing about the purpose may have been exarcerbated by the absence of information about care plans. Despite clear guidance in Box B3, more than one-third (35%) of the *Form 4s* we reviewed neither included nor made any reference to the person's care plan. Care plans should not only details of the person's care and treatment but also the arrangements in terms of organising the environment to provide that care and treatment. They are critical in understanding the reasons why an application for an authorisation of a deprivation of liberty has been made.

3.6.7 *Less restrictive alternatives*: The text for Box B9 (c) requests the Managing Authority to describe the alternatives to a deprivation of liberty that have been considered. In the sample of 37 *Form 4s* we reviewed, the *only* alternative described was that of allowing the patient to return home. Invariably, this was rejected, on the grounds that he or she would not have access to treatments that were believed only to be available in a hospital setting and/or would be at serious risk of self-neglect. There was no evidence that any consideration had been given to changes to the environment that might make it less restrictive. This is *not* to say that Managing Authorities were necessarily preventing their patients from leaving a ward, or even a hospital (for example, on trips with staff escorts). However, where such practices were described, they were reported as part of the care and treatment rather than as arrangements that might change a deprivation of liberty into restrictions on a patient's freedom of movement. An example is provided in Table 3.4.

Table 3.4: 'Less restrictive' arrangements not recognised

a) [*X*] is being prevented from leaving without staff escort.
b) He has absconded in the past from a less restrictive environment and has come to harm.
c) There are no alternatives.
d) Vulnerable to abuse due to his sexual disinhibition and at risk of harm from exposure and self-neglect.

3.6.8 *Restraint:* Managing Authorities seemed unsure of their power to restrain patients under s. 6 of the MCA. Instead, the use of restraint, which includes restrictions on patients' freedom of movement, served as another 'rule of thumb' to signal a deprivation of liberty. The excerpt in Table 3.5 provides an illustration..

Table 3.5: Alternative legal frameworks for authorising restraint not recognised

> […] We offer to take [*X*] out as much as possible or when she requests, but by denying her requests to go home we are concerned that we are depriving her of her liberty. Her daughter has requested we limit her phone calls to her as she finds calls from [*X*] very tiring. Whilst we remind [*X*] that she may have only called daughter five minutes ago and suggest she waits until later, we do assist her in phoning if she remains insistent. [*X*] does not have a home to go to, and we would not allow her to leave the ward unescorted […]

3.7 Decision-making in the six statutory assessments

3.7.1 Upon receipt of a *Standard Request for Authorisation*, the Supervisory Body commissions six statutory assessments (see Fig. 1.2); this comprises the second stage of the MCA-DoLS procedure. There was variation in the way that representatives of the Supervisory Bodies commissioned the assessments. Some had a full-time group of Best Interests Assessors, who also act as 'Advisers'; others kept a list of appropriately qualified professionals on whom they could call; while another group used a mixture of both systems. None of the three Supervisor Bodies employed medical practitioners as full-time Mental Health and/or Eligibility Assessors.

3.7.2 Of the six assessments, there are four where the decisions made have implications for the interface between the MCA-DoLS and the MHA: the Mental Health, Eligibility, Capacity, and Best Interests Assessments. These assessments are recorded on a series of forms. Our comments on the first three of these assessments are based on reviews of the content of the forms, supplemented with interviews with practitioners. For the fourth, we had access to 39 completed *Form 10*s recording Best Interests Assessments; thirty-seven of these related to the same thirty individuals for whom *Form 4* applications had been made.

3.7.3 *The Mental Health Assessment*: As Fig. 3.1 shows, the Mental Health Assessment (*Form 6*, see Appendix IIIc) must be carried out by an appropriately qualified medical practitioner who, at the least, has undertaken additional training; where possible, he or she should also have experience of the patient's clinical condition. The intended purpose of the assessment is to ensure that the patient has a 'mental disorder' within the meaning of the MHA (that is, 'any disorder or disability of mind') and therefore comes within the scope of Art. 5 of the ECHR. In contrast with the MHA, however, for men and women with a learning disability, that disability need not be associated with abnormally aggressive or seriously irresponsible conduct (Sch.A1, para.14).

3.7.4 In terms of completing *Form 6*, the Mental Health Assessors all reported that C1 or C2 and the first part of C3 were generally straightforward. It was the second part of section C3, requiring an assessment of the likely impact on the person's mental health of a deprivation of liberty, that was perceived to be more difficult. The following response was typical:

> …you're just shooting in a blind alley really by commenting on the impact of the DoLS on the patient's mental health; I find that really difficult to comment on.
>
> Mental Health/Eligibility Assessor, interview

3.7.5 Such comments reflected the fact that the Mental Health Assessors had not normally met the patient before. In addition, particularly when that person was receiving treatment for a physical disorder, there was often limited background material available about his or her mental disorder. In some cases, it was reported that GPs refused to provide information about patients because the Assessor was not the treating clinician. While conscientious attempts to seek such information were reported, we gained the impression that the second part of the Form was regarded as of less importance than the first.

3.7.6 *The Capacity Assessment*: As Fig. 3.1 shows, the Capacity Assessment (*Form 7*, see Appendix IIId), can be completed by medical practitioners eligible to act as Mental Health Assessors or by Best Interests Assessors. Its purpose is to establish that the person lacks the capacity to decide whether or not to be accommodated in the relevant place for the purpose of being given the relevant care or treatment (Sch. A1, para. 15). The standard *Form 7* has a number of striking features. The first is the absence of any statement describing the proposed arrangements for providing care and treatment; instead, the relevant sections (C1 and C2) relate to

'being accommodated'. This does not invariably mean the same. After all, patients may agree to being accommodated in a particular ward but not to the arrangements made for their care and treatment. Secondly, although Assessors are asked to confirm that, in their opinion, all practicable steps have been taken to assist the person to make his or her own decision, there is no requirement to describe these steps. Thirdly, the format comprises tick- boxes, apart from a section at the end, asking those the Assessors to: '*Give your reasons for deciding that it has or has not been established that the person lacks capacity to make their own decisions about whether to be accommodated in hospital or care home for the purpose of being given the proposed care and/or treatment because of an impairment or, or a disturbance in the function of the mind or brain*'.

3.7.7 All three representatives of Supervisory Bodies reported concerns about *Form* 7, to which they had already responded or were planning to respond. One had replaced the standard *Form* 7 with a new version, based upon the *FACE Mental Capacity Assessment Tool*[76]. This assessment comprises free text boxes in which the assessor is required to state the decision that needs to be made; comment on the person's capacity with respect to each of the four defined components of capacity (set out in s.3 (1) of the MCA); and describe what practical steps have taken to help the person gain or regain capacity to make the decision for him or herself. The second representative had undertaken negotiations to allow a similarly redesigned capacity assessment to be implemented. The third representative had no plans to introduce a new version but had advised Best Interests Assessors to use the text box at the end of the standard Form to relate difficulties in responding to any of elements of the 'functional test' (s3.(i)) to the 'diagnostic test' set out in s. 2 (i) of the MCA.

3.7.8 *The Eligibility Assessment*: As Fig. 3.1 shows, the Eligibility Assessment (*Form 9*, see Appendix IIIe) can be carried out by an appropriately qualified medical practitioner or a Best Interests Assessor who is also an Approved Mental Health Practitioner. It comprises five questions to determine whether the person is ineligible for the MCA-DoLS under Sch.1A (see Table 1.2).

3.7.9 Of the five questions, the first four relate to Cases A-D (see Table 1.2) and are matters of fact. Briefly, someone is ineligible for the MCA-DoLS if he or she is

[76] FACE Recording and Measuring Systems. *Mental Capacity Assessment Tool.* Available from http://www.face.eu.com.

already detained in hospital under the MHA for assessment or treatment of a mental disorder (Case A), or is subject to other compulsory measures under the MHA and a deprivation of liberty would conflict with a requirement imposed under that legal framework (Cases B-D). The fifth case (Case E) excludes from the MCA-DoLS patients who 'fall within the scope of the MHA', that is, broadly, those who are liable to be, but are not yet, detained in hospital for treatment of a mental disorder under ss. 2 or 3 of the MHA and who object, or are likely to object, to admission to hospital and/or elements of their treatment.

3.7.10 At first sight, the Eligibility Assessment seems straightforward; it should require only a good knowledge of the MHA. However, it is not unproblematic. The tick box format means that the basis for this important decision is not available for scrutiny and challenge. Similarly, we cannot know whether, for example, Best Interests Assessors who are also Approved Mental Health Practitioners understand the task and are applying the criteria in the same way as psychiatrists.

3.7.11 Medical practitioners who acted as Eligibility Assessors reported that their assessments could lead to some difficulties with clinical colleagues, particularly those in general hospitals. They attributed this to the 'legal' approach they had to adopt, which differed from the clinical, pragmatic, approach the treating clinical team might take, and, indeed, the Eligibility Assessors told us, they themselves might adopt with their own patients. They provided a number of examples, all involving individuals in general hospitals with physical disorders that may be associated with mental disorders (for example, HIV/AIDS; long-standing alcohol misuse that did not amount to dependence), where they felt that they had been placed under pressure *not* to find patients ineligible for the MCA-DoLS.

3.7.12 The Eligibility Assessors reported that, in these situations, they believed that the treating clinicians were reluctant for their patients to be assessed under the MHA because of concern that they might then be transferred to a general psychiatric ward where the care would be less good, or even discriminatory. While we did not interview medical practitioners in general hospitals, the implication is that they have a 'rule of thumb' that the best interests of patients with physical conditions that lead to, or are associated with, mental disorders are better protected by the MCA-DoLS than the MHA.

3.7.13 The Mental Health/Eligibility Assessors told us that, at least at when the MCA-

DoLS were introduced, Best Interests Assessors who were not also Approved Mental Health Practitioners sometimes seemed to lack confidence. It was reported that they:

> ….generally pay an awful lot of heed to the psychiatrists. In Mental Health Act assessments the AMHP [*Approved Mental Health Practitioner*] is quite happy to take a different view to the doctor if he thinks that's appropriate, in fact that's important because all three [*the psychiatrist, the AMHP and the second registered medical practitioner*] of us decide…but in this a lot of the Best Interest Assessors are not AMHPs and I think they're not quite as used to going against a doctor.
>
> Mental Health Act/Eligibility Act Assessor, interview

3.7.14 Interestingly, the same point was made by Best Interests Assessors who were not also Approved Mental Health Practitioners: they reported that, particularly in a psychiatric hospital, they had sometimes felt intimidated, feeling that they were 'outsiders'. We asked few questions about changes over time, but among those Best Interests Assessors who were also Independent Mental Capacity Advocates, some comparisons were made with the challenges they had faced following the introduction of their involvement in 'serious medical treatment'[77] in general hospitals. It was expected that relationships would improve and indeed some Eligibility Assessors reported that, as they worked with Best Interest Assessors, such improvements had taken place.

3.7.15 *The Best Interests Assessment*: As Fig. 3.1 shows, the Best Interests Assessment (*Form 10*, see Appendix IIIf) can be completed by an appropriately trained Social Worker, Registered Nurse, Occupational Therapist, or a Chartered Psychologist, as well as an Approved Mental Health Practitioner. The purpose of the assessment (Sch.A1, para. 16) is to determine whether the proposed arrangements for the patient's treatment and care comprise, or are likely to comprise, a deprivation of liberty (Box D5). If this is the case, an assessment must be made as to whether that deprivation is in the best interests of the person (Box D6), is *necessary* (rather than simply desirable) to prevent harm to the person (Box D7), and is a proportionate response to the likelihood and seriousness of that harm (Box D8) (Sch.A1, para.16). Since there is no appeal to the decision made by the Best Interests Assessor, this role is, perhaps, the most critical in the whole MCA-DoLS procedure.

[77] Redley,M., Clare, I.C.H., Luke, L., & Holland, A.J.(2010). Mental Capacity Act (England and Wales) 2005: The Emergent Independent Mental Capacity Advocate (IMCA) Service. *British Journal of Social Work, 40*(6), pp. 1812-1828.

3.7.16 The analysis of the *Form 10s* suggested that Box D5 was often rather poorly explained, in that broad, rather legalistic, terminology was used, rather than a precise description of those aspects of the proposed arrangements for the patient's care and treatment that comprised a deprivation of liberty. An example is presented in Table 3.6.

Table 3.6: A deprivation of liberty not well-described

> He lacks the capacity to consent to any aspects of his care and treatment and is under complete and effective control of his care providers with regard to his care, treatment, assessments and residency. Based on all available evidence it is my opinion that the proposed arrangements for [*X*]'s care in hospital accumulatively amount to a deprivation of his liberties.

3.7.17 When asked about identifying a deprivation of liberty, the Best Interests Assessors we spoke to all referred to the importance of considering each case on its merits, eschewing a simple checklist of factors, and taking into account developments in the case law. Some of them expressed concerns that the process was highly subjective. Nevertheless, regardless of their level of confidence, a significant majority of *Form 10s* were completed in a similar way. Assessors wrote at length about the patient's physical condition and/or mental health needs, the care and treatment being received to meet those needs, and the provision of personal care.

3.7.18 Considerable emphasis was placed on patients' perceived wishes and behaviour. Strikingly, the more frequently an individual challenged the arrangements, by, for example, asking or attempting to leave a ward, the more likely it was that a deprivation of liberty was identified. Such a view was consistent with our interviews, in the course of which, discussing how they identified a deprivation of liberty, we were told that:

> …[*it's*] the intensity, duration and frequency of somebody asking to leave…or people indicating that they are not happy and it's a lot more intense…nine times out of ten it has to do with them wanting to leave the home or hospital that they are living in and they cannot understand the reasons why they need to be there.
>
> Best Interests Assessor, interview

> It's the number of times somebody's trying to leave, the intensity and their awareness; so certainly somebody who's aware that they're being prevented from leaving, that's a fairly clear deprivation of liberty. With some of the people … I think in some cases if it's a fairly fleeting awareness or sense that they feel they need to leave, if it lasts only for a short period of time and they're fairly easily distracted and then they settle, and it passes and they're not at all concerned, then I'm inclined to

> say that's not a deprivation of liberty. I go quite a lot on the person's distress.
>
> Best Interests Assessor, interview

3.7.19 The use of restraint was also almost invariably viewed as a deprivation of liberty, as were situations in which family members had asked for the patient to return home with them. It seemed, therefore that, alongside verbal or physical challenges by patients, restraint and certain types of family wishes provided 'rules of thumb' for a deprivation of liberty. The possibility that, for a person receiving treatment for a mental disorder, objection could lead to consideration of the use of the MHA was, however, sometimes missed.

3.7.20 In keeping with this suggestion, the text in Box D5 often simply documented, almost as a checklist, the presence of limits on the person's freedom (locked doors, monitoring and supervision, the use of restraint, requests to go home). There was a focus on the 'nature or substance' of restrictions rather than their 'degree or intensity' as was established domestically by the judgement in *JE*[78].

3.7.21 The next box, Box D6, asks Best Interests Assessors to consider whether or not, if the proposed arrangements amount to depriving someone of his or her liberty, why they are, or are not, in that person's best interests. In both general and psychiatric hospitals, individuals' best interests seemed to be understood rather narrowly, in terms of the person's clinical needs, rather than the *arrangements* for meeting those needs. Rarely did these arrangements appear to be evaluated in light of their possible duration or effect upon the individual concerned. Such findings suggest that it was difficult for Best Interests Assessors to distinguish between the arrangements for providing treatment and care and the treatment and care itself.

3.7.22 Like their counterparts in the Managing Authorities, Best Interests Assessors seemed to have difficulty in thinking about less restrictive alternatives such as modifications to the environment: almost invariably, the only option considered was that of returning home. This was rarely viewed as in the best interests of the person because it was assumed that care and treatment could only be provided in a hospital setting. A typical example is shown in Table 3.7.

Table 3.7: Returning home is not a less restrictive possibility

[78] *JE v DE and Surrey County Council*, *op. cit*., n. 48, para. 77.

> The imposed restrictions will ensure that [*X*] does not come to harm due to her vulnerability [… *X*] lacks capacity to consent/comply with a treatment plan; in the event that . [*X*] left the building she would be unable to maintain any level of safety for herself. She would be vulnerable to exploitation of all forms […*X*] need[*s*] a lot of prompting and encouragement to complete activities of daily living, without support [*X*] would be at risk of physical ailments such as dehydration, infection, malnutrition…

3.7.23 Boxes D7 and D8 ask the Best Interests Assessor to consider whether a deprivation of liberty is necessary and proportionate. There was no evidence from the *Form 10s* or our interviews that a person lacking capacity to make a decision about their care and treatment could be restrained, subject to conditions, under s. 6 of the MCA.

3.7.24 Of concern, while restraint was viewed as demonstrating that the patient was being deprived of his or her liberty, in seven of the eleven cases in which the use of restraint was reported in the context of treatment in a psychiatric hospital for a mental disorder it was *not* viewed as objection suggesting that an assessment under the MHA should be considered. A typical example is shown in Table 3.8.

Table 3.8: The need for restraint not seen as indicating objection

> Ms [*Y*] could not recall visiting [*Z (specialist PCT-commissioned unit for older people with dementia and 'challenging behaviour')*] or having said that she liked it, and stated that she does not want to live there. She mentioned instead, that she wished to return to her previous care home. There is evidence that Ms [*X*] finds changes of environment distressing and that in the past this has caused her to become agitated and highly resistive to care interventions for a prolonged period of time. Furthermore, Ms [*X*]'s daughter and former carer would prefer that her mother is discharged back to her care. This is because she is concerned that her mother would be at risk of harm from other residents at [*Z*]. I feel it is more than likely that Ms [*X*] will become agitated and highly resistive on being transferred to [*Z*] and that she will require a high level of observation and frequent restraint and restriction by staff in order to provide care and avoid harm to herself and others. In my opinion the conditions of her care at [*Z*] will amount to a deprivation of Liberty.

3.7.25 In support of the interviews with the Mental Health Act/Eligibility Assessors, Best Interests Assessors seemed reluctant to, or perhaps did not understand that they could, question a decision that the patient was not ineligible for the MCA-DoLS.

3.7.26 Finally, there was an absence of information in the Forms about the views of family and others who knew the patient well. Of the 39 *Form 10s* that were analysed, 29 (74%) indicated that 'interested persons' had been consulted (Part C1, Box C), and the names and addresses of these individuals were provided. However, only one Form referred directly to information gained from these voices sources. As a result, the voices and insights of those with knowledge of the person, and, probably, their wishes, values, and beliefs, were missing. This may suggest that the experiences of the single Relevant Person's Representative to whom we were able to talk are not atypical.

> I was just telephoned and told they were going to do it [*recommend a deprivation of liberty*], and when I expressed my concern it wasn't taken on board. So what they are putting in the report, that all this has been agreed with me, where agreed means I was consulted… I disputed that… I said that is not a consultation, you are informing me…
>
> Relevant Person's Representative, interview

3.7.27 As Fig.1.2 shows, if all six assessments support a deprivation of liberty, the Supervisory Body grants the authorisation, and appoints the person recommended by the Best Interests Assessor to act as the person's representative (with provision for the appointment of an Independent Mental Capacity Advocate in certain circumstances). Representatives of the Supervisory Bodies told us that they reviewed very carefully the period for which the Best Interests Assessor had recommended that a deprivation of liberty should be authorised and any suggestions about conditions for authorisation (Sch.A1, paras. 50-51).

3.8 Patients deemed ineligible for the MCA-DoLS

3.8.1 For eleven of the thirty individuals whose paired *Forms 4* and *10* we received, the Best Interests Assessors concluded that the requirements under Part E of *Form 10* (see Appendix IIIf) were not met. For two patients, there was a deprivation of liberty, but it was not judged to be in the person's best interests (E1). In both these cases, an Eligibility Assessment was requested and the patients were subsequently detained for treatment under the MHA. For the remaining nine, the Best Interests Assessor decided that there was no deprivation of liberty (E2). Of these, three had already been discharged. The remaining six Forms were scrutinised for any indication that someone who lacked capacity to consent to the arrangements for his or her care and treatment and did not appear to object was being deprived of his or her liberty without access to the MCA-DoLS.

3.8.2 There was one such person: like *HL*[79] she was a compliant informal patient in a psychiatric hospital. She was described as dependent upon staff support to meet all her needs, and as requiring both bed rails and a lap strap to prevent her from falling. The use of such restraints may be very reasonable. Of concern, though, this woman's admission resulted in separation from her child, and, though reported, this passed without comment (see Table 3.9).

Table 3.9: A compliant patient lacking capacity

> [*X has*] mild learning disabilities, communication impediment and mental health problems and currently elevated mood. [*X*] is married with one son and has lived in the family home for many years. [*X*] has received ongoing support from learning disability community nurse team who know her well and continue to provide a high level of support. [*X*] left her husband/family home on [*Y date*] following an argument with her husband. There have been long-standing marital problems and this had been affecting her mental state and she had indicated she wanted to leave her husband. [*X*] went to stay with her elderly parents who live in a warden control flat. Her husband contacted the police as he was worried about her safety; the police conducted a welfare check and raised safeguarding concerns with the local authority both for [*X*] and her child. [*X*] was advised by the duty manager of the local authority that she should present as homeless to the city council, due to her severe speech impediment this would be impossible for her to undertake without support. Her elderly parents accompanied her and there were sent to different departments until she was offered a placement at a woman's refuge. [*Xt*] found this experience distressing and frightening. [*X's*] consultant and community nurses were concerned about the impact on her mental health and felt she needed supported accommodation who would understand her needs, unfortunately the Local authority was unable to secure accommodation until the Friday by which time her mental health which had been changeable, deteriorated and the home was unable to provide the level of care she required. [*X*] was assessed under the Mental Health Act but agreed to voluntary admission. Since admission she has remained frightened, distressed and anxious and requires high levels of reassurance.

3.9 A well-completed *Form 10*

3.9.1 Much of the analysis of the Forms has been driven by problems in the way they are completed. This is not intended as criticism, for the task expected of Managing Authorities and Best Interests Assessors is a demanding one. It involves an

[79] *HL v The United Kingdom, op. cit.,* n. 14

understanding of the person's care and treatment, the arrangements for the provision of that care and treatment, the person's response, and the application of complex clinico-legal concepts such as 'purpose', 'objection', 'restriction' and the elusive 'deprivation of liberty'. Moreover, this appreciation has to be expressed in writing, and expressed with sufficient skill to enable the Supervisory Body to grant or withhold its authorisation of a deprivation of liberty. In Table 3.10, we present an example of well-crafted answers to the four free text boxes: D5, D6, D7, D8 in *Form 10*. While we do not believe that the arrangements described by the Best Interests Assessor amount to a deprivation of liberty, the responses themselves are a model of clarity and precision.

Table 3.10: A well-written Form

D5: The reasons for my opinion concerning whether or not the proposed arrangements for the person's care and/or treatment amount to depriving them of their liberty in the hospital or care home are:

Mr [*X*] has Alcohol Liver Disease, hepatic encephalopathy and chronic kidney disease stage three. He suffered bifrontal intracerebral and subdural bleeding in [*Y year*] and he now has increased confusion. Mr [*X*]'s liver and spleen are enlarged and seriously limited in their function. Mr [*X*]'s condition has left him with cognitive impairment so he now lacks capacity to make decisions about all daily living tasks. He is unable to process information and is therefore unable to make decisions based on any information given to him. Mr [*X*] is not allowed to leave the ward unsupported because he is unable to care for himself and will be at significant risk of harm. He is monitored day and night. Mr [*X*] regularly asks to go home but he cannot remember where he lives; prior to his admission, he once went back to the house he has not lived in for 15 years. The proposed arrangements for Mr [*X*]s care and treatment therefore amount to depriving him of his liberty.

D6: If the proposed arrangements amount to depriving the person of their liberty, the reasons for my opinion that they are, or are not, in the person's best interests are:

Mr [*X*]'s condition has damaged his overall functioning and this has seriously affected his ability to take care of any of his daily living tasks. He is so physically weak that he cannot carry out any tasks, even when prompted. Mr [*X*] is unable to maintain his physical and mental health without round-the-clock physical support. Mr [*X*] has very few appropriate answers to simple questions; he answered "I am alright" to all the questions I asked him, even when the questions did not relate to his feeling or condition. Mr [*X*] lacks the ability to make any decisions, even the most basic ones. He requires physical support and lots of prompting to eat or drink, to have a shower or bath, dress and groom. Mr [*X*] wanders around aimlessly and in the past, he has been lost but luckily he was found asleep, however in inappropriate places. When

found, on one occasion he was soaked in his own urine and once he was bleeding heavily. In conclusion, I feel that the proposed arrangements which amount to depriving Mr [*X*] of his liberty are in his best interests.

D7: If the proposed arrangements amount to depriving the person of their liberty, the reasons for my opinion that they are, or are not, necessary in order to prevent harm to the person are:

Mr *X*'s condition, discussed in D5, shows that his cognitive impairment is affecting his ability to attend to his daily living functions. Mr [*X*] lacks coordination and falls and he is unable to get up without support. Due to his weakness, he is unable to call for help even when the mobile phone is in his hand. Mr [*X*] lacks road safety skills so will be in serious danger on the roads. Mr [*X*] is unable to remember basic information or numbers so is unable to get to a destination safely. Mr [*X*] is at serious risk of self neglect due to his inability to make himself a drink or snack or to feed himself without prompting and physical support. Therefore the proposed arrangements which amount to depriving Mr [*X*] of his liberty are necessary in order to prevent him from coming to harm.

D8: If the proposed arrangements amount to depriving the person of their liberty, the reasons for my opinion that they are, or are not, a proportionate response to the likelihood of the person otherwise suffering harm and the seriousness of that harm are:

Although Mr [*X*] has cognitive impairment affecting his decision-making and functioning, he is still involved in that process. The hospital staff still try their best to include him in the process. The staff acknowledge any little verbal and non-verbal communication and they continue to prompt him to contribute. They limit the decisions they make on his behalf to his care and treatment to keep him safe and follow prescribed treatment. The family is consulted and acknowledged as those acting in his best interests. His family are included in the decision- making process because they know Mr [*X*]'s likes and dislikes and his way of thinking. They also bring in cultural and religious background. Other decisions are left for Mr [*X*]'s next of kin to make. Although Mr [*X*] is occasionally unaware of his surroundings due to his condition, he is still respected and he is offered privacy during personal care; confidentiality is still maintained when discussing his condition or personal details and his dignity is maintained. Therefore I am of the opinion that the proposed arrangements which amount to depriving Mr [*X*] of his liberty are a proportionate response to the likelihood of his suffering serious harm.

3.10 Falling through the gaps

3.10.1 The examination of decision-making suggested some gaps, where individuals who lack capacity to make decisions about arrangements for their care and treatment

might be deprived of their liberty in hospital without the protections of either the MCA-DoLS or the MHA. Two groups may be at particular risk:

(i) compliant, informal, patients in psychiatric hospitals whose lack of capacity to give or withhold consent to remaining there for assessment and/or treatment of a mental disorder goes unrecognised. This group of men and women may be, but are not necessarily, at particular risk of not being identified if they do not have a diagnosed clinical condition, such as dementia or learning disability, associated with 'an impairment of, or a disturbance in the functioning of, the mind or brain' (s. 2(1), MCA 2005) that alerts treating clinicians and/or the Managing Authority to their possible difficulties;

(ii) patients receiving care and treatment in a general hospital for a physical disorder, who are compliant and whose lack of capacity to make decisions about arrangements for their care and treatment is not identified. Our interviews with Mental Health/Eligibility Assessors suggested that some of these patients are men and women with dementia, that has not previously been diagnosed, who are admitted through Emergency Departments to designated locked wards for older people.

3.11 Summary

- Among 'early adopters', the MCA-DoLS regulations seem to have some support. Nevertheless, even among the most enthusiastic, there were concerns about the concept of a deprivation of liberty, the demands of the procedure, and both the content and status of the available guidance.

- Our findings suggested that practitioners experience a number of problems, which they attempt to resolve by the use of 'rules of thumb' (simple and easily applied principles that need not be absolutely reliable and accurate). For psychiatrists, the 'primacy' of the MHA seems to provide one such 'rule of thumb'. They viewed the MHA as the appropriate legal framework for patients receiving 'active treatment' intended to improve their mental health, with the MCA-DoLS being seen as a framework for detaining men and women receiving what they term 'care' while awaiting discharge to residential accommodation. In contrast with their colleagues in psychiatric hospitals, medical practitioners in general hospitals were reported by Mental Health/Eligibility Assessors to be rather reluctant to consider the use of the MHA for the treatment of mental disorders in patients admitted to general hospitals for physical disorders.

- Both Managing Authorities, making applications for assessments for the MCA-DoLS, and Best Interests Assessors, carrying out their assessments, often conflated the arrangements for care and treatment with the care and treatment itself. Restraint, in particular, but other restrictions too, patient challenges, and the family's wish for the person to return home with them, were also used as 'rules of thumb' to signal a deprivation of liberty. There was very limited evidence to support the claim that the assessment procedure promoted consideration of less restrictive alternatives such as environmental modifications that might prevent the need for a deprivation of liberty.

- While Best Interests Assessors viewed patient challenges and restraint by as indicators of deprivations of liberty, in the context of treatment for a mental disorder in a psychiatric hospital, they were not always viewed as markers of objection that might suggest consideration of the MHA.

- A significant minority of *Form 4*s completed by Managing Authorities did not attach or refer to the care plan, which should contain details of the arrangements for the provision of the patient's care and treatment as well as the care and treatment itself. Moreover, while almost three-quarters of the *Form 10*s completed by Best Interests Assessors referred to consultations with 'interested parties', only one referred directly to the information gained. This meant that the voices and insights of those with knowledge of the patient, and, probably, their wishes, values, and beliefs, were missing.

- While many of the standard Forms we examined were not well-completed, a number of aspects of these Forms are unhelpful to practitioners: they can be repetitive and contain material that, in places, is complex and/or slightly misleading or seems unnecessary. Moreover, the completion of these Forms does not always ensure that crucial elements of the MCA-DoLS procedure (for example, the nature of any steps to make the patient's environment less restrictive that have been considered and tried, and their outcome; the contribution made by the person's family or friends to the Best Interest Assessor's decision-making) are transparent and open to challenge.

- Two groups may be at particular risk of falling between the gaps so they are not protected by the MCA-DoLS *or* the MHA: men and women who lack capacity to make decisions about arrangements for their care and treatment, are compliant, and receive assessment and treatment either as (i) informal patients in psychiatric hospitals or (ii) as patients in general hospitals.

CHAPTER 4: THE INTERFACE BETWEEN THE MCA-DOLS AND THE MHA: QUANTITATIVE DATA

4.1 Introduction

4.1.1 There is evidence that applications for a deprivation of liberty under the MCA-DoLS are made less often than initially anticipated, while a greater proportion are authorised[80]. Information about these applications and authorisations provides an indicator of the way in which the regulations and the procedure they set out are interpreted by Managing Authorities and Supervisory Bodies.

4.1.2 In this Chapter, we attempt to examine aspects of the interface between the MCA-DoLS and the MHA by comparing the characteristics of men and women (i) for whom MCA-DoLS applications have been made by Managing Authorities in services commissioned by PCTs (mainly general or psychiatric hospitals) and authorised by Supervisory Bodies in those PCTs, with those of patients (ii) admitted informally to a psychiatric hospital for assessment and/or treatment of a mental disorder and for whom a MCA-DoLS application has not been made or authorised, or (iiI) detained in hospital for treatment of a mental disorder under s.3 of the MHA.

4.1.3 Before focussing on the interface with the MHA, however, we first compare MCA-DoLS applications to, and authorisations by, Supervisory Bodies in PCTs with those from local authorities (LAs). The subsequent comparisons are carried out, using an MHA data set, the Mental Health Minimum Data Set (MHMDS). Further information about the use of the MHMDS, the choice of s. 3 detained patients, and the analyses presented is provided in Appendix II.

4.1.4 Considerable caution is needed in interpreting the findings because of the different formats of the two data sets we have used: the MCA data set provides information about *applications* and *authorisations* for the MCA-DoLS, but does not link this to individuals. We cannot know, for example, whether three authorised applications relate to three separate people, or to one person for whom three applications have been made. In contrast, in the MHMDS, each *patient* has a unique identifier, which prevents double-counting; the data set has other limitations, however. To estimate

[80] NHS information Centre, Community and Mental Health (2010), op. cit., n. 58.

the potential impact on the MCA-DoLS data set of the double-counting issue, we make use of additional information relating to twenty *individuals* from our sample of MCA-DoLS Forms (see Table 2.1).

4.1.5 All the data relate to the period between 1st April 2010 – 31st March 2011, the second full year after the introduction of the MCA-DoLS Safeguards, and the most recent for which complete information was available during the period of our study.

4.2 MCA-DoLS applications and authorisations: patient characteristics

4.2.1 The processes for the collection and recording of MCA-DoLS applications and authorisations by the Health and Social Care Information Centre are changing[81]. At the time when the data for the were collected, applications made to PCTs (most of which relate to general or psychiatric hospitals) could be distinguished on the database from those made to local authorities (mostly relating to care homes), supporting comparisons between these two sources. However, from 1st April 2013, all applications have been made to, and authorised by, Supervisory Bodies in local authorities (LAs).

4.2.2 *The primary recorded disability and other characteristics of MCA-DoLS applications made by PCTs or LAs, and authorisations*: the primary disability, and other characteristics, of the men and women for whom MCA-DoLS applications were made and authorised are shown in Tables 4.1 and 4.2.

Table 4.1: Primary disability as recorded in the MCA-DoLS data base (Q2-Q4 totals)

		Applications		Authorisations	
		PCT	LA	PCT	LA
		1,771	5,137	876	2,952
Disability leading to application	Dementia	42%	56%	44%	59%
	Other mental health issue	18%	13%	17%	13%
	Learning disability	13%	15%	14%	14%
	Physical/frailty/illness	25%	14%	24%	13%
	Hearing, visual impairment or dual sensory loss	0%	1%	0%	1%

Notes: a) only Q 2-4 data have been used because of the change in recording at the start of this quarter to one primary disability rather than all relevant disabilities; b) through rounding up, the figures may not add up to 100%.

[81] The latest information on changes to the DoLS collection can be found at http://www.hscic.gov.uk/dols.

4.2.3 There are slight differences between applications from Managing Authorities in PCTs and those from LAs. While both kinds of applications are dominated by people with dementia, applications to Supervisory Bodies in PCTs are a little more varied and are rather more likely to include men and women with physical disability, frailty and/or temporary illness, or a mental health condition other than dementia. This is not unexpected, since applications to PCTs will normally relate to patients in general or psychiatric hospitals. Perhaps a little surprisingly, since many more people with learning disabilities are in residential services than in hospitals[82], the proportion of applications from Managing Authorities in PCTs and LAs was very similar.

4.2.4 The differences between the sources of applications for the MCA-DoLS are reflected in the authorisations. While this finding suggests an encouraging consistency in the way applications are interpreted by the Supervisory Bodies in PCTs and those in LAs, it may not be of particular importance. In the three geographical areas in which our study was based, the Supervisory Bodies were integrated so that the same group of practitioners was responsible for authorising both applications from PCTs and local authorities. If this is the case nationally (as it has been since 1st April, 2013), then consistency in the treatment of applications from different sources is unsurprising.

4.2.5 Table 4.2 shows other characteristics of the men and women for whom applications for the MCA-DoLS were made to PCT or LA Supervisory Bodies and authorised.

[82] Emerson, E., Hatton, C., Robertson, J., Roberts, H., Baines, S., Evison, F., & Glover, G. (2012). *People with Learning Disabilities in England 2011*. Lancaster: Improving Health and Lives Learning Disabilities Observatory.

Table 4.2: Other characteristics

		Applications		Authorisations	
		PCT	LA	PCT	LA
		2,270	6,741	1,134	3,838
Gender	Female	43%	57%	42%	56%
	Male	57%	43%	58%	44%
Age	18-64	41%	27%	39%	26%
	65-74	15%	12%	15%	12%
	75-84	26%	31%	28%	32%
	85+	18%	29%	18%	29%
Ethnicity	White	89%	93%	92%	94%
	Asian or Asian British	3%	2%	2%	2%
	Black or Black British	2%	2%	2%	2%
	Mixed	1%	1%	1%	1%
	Other ethnic groups (combined by research group)	0%	0%	0%	0%
	Not recorded	4%	2%	3%	1%
Religion/belief	Christian	43%	59%	45%	60%
	Hindu	1%	1%	0%	0%
	Jewish	1%	1%	1%	1%
	Muslim	2%	1%	2%	1%
	Buddhist or Sikh (combined by research group)	0%	0%	0%	0%
	Other religion	1%	2%	1%	2%
	None	9%	9%	8%	8%
	'Not stated' (using HSCIC terminology)	44%	28%	43%	27%
Sexual Orientation	Heterosexual	53%	61%	54%	62%
	Lesbian, gay, bisexual, or other	0%	0%	0%	0%
	Preferred not to say	3%	2%	2%	2%
	Not known	44%	36%	43%	35%

Notes: a) the data have been collected from quarterly, rather than annual, returns, as only these contain the necessary detail; b) as a result of rounding up, the figures may not add up to 100.

4.2.6 Applications to Supervisory Bodies in PCTs are *more* likely than those to LAs to relate to people aged 18-64 years, and to men rather than women. However, they are slightly *less likely* to relate to people from a White ethnic background. The differences between the sources of applications are reflected in the authorisations.

4.2.7 *Applications and authorisations from different settings*: applications and authorisations for the MCA-DoLS from patients in psychiatric hospitals cannot be

distinguished from those relating to general hospital patients. We are, not, therefore, able to describe any differences between patients in the two different settings. Instead, we examined the characteristics of different groups in hospital under different legal frameworks.

4.3 Comparison of three groups: authorisations under the MCA-DoLS, informal, and s. 3 MHA patients

4.3.1 *Characteristics of MCA-DoLS*, *informal, and s. 3 patients*: using all the information available in the two databases, Table 4.3 shows the characteristics of individuals for whom the MCA-DoLS has been authorised by a PCT Supervisory Body, some of whom may be in a psychiatric hospital, compared with patients who are informal or detained under s. 3 of the MHA[83]. It is important to note that people with learning disabilities will be under-represented in the MHMDS, as no data are collected from services designated for this group of men and women.

Table 4.3: MCA-DoLS authorisations, informal, and detained patients

		Authorisations under the MCA-DoLS	Informal or detained patients	
		PCT 1,134	Informal 13,019	s. 3 33,206
Gender	Female	42%	49%	48%
	Male	58%	50%	52%
Age	18-64	39%	73%	82%
	65-74	15%	11%	10%
	75-84	28%	11%	6%
	85+	18%	5%	2%
Ethnicity	White	92%	87%	75%
	Asian or Asian British	2%	3%	8%
	Black or Black British	2%	3%	12%
	Mixed	1%	1%	2%
	Other ethnic groups (combined by the research group)	0%	1%	2%
	Not recorded	3%	4%	1%

Notes: a) due to rounding up, the figures may not add up to 100%; b) because of the way that the MCA-DoLS data are recorded, some individuals may be counted more than once; c) only informal and s. 3 patients in hospital for more than one night are included[84]; d) where there are no data that are 'not recorded', this row is omitted; e) people with learning disabilities are under-represented in the MHA data.

[83] Information about the way these groups were formed can be found in Appendix II.

[84] The approach of considering only those who have been informally admitted to hospital for more than one day has been supported by Dr. Claire Thompson, Principal Information Analyst with the Community & Mental Health

4.3.2 The most striking differences between the three groups relate to age, gender and ethnicity. Compared with the two other groups, men and women subject to the MCA-DoLS are very much *more likely* to be aged 75 years, and aged 85 years or more in particular, and to be men. Importantly, in contrast with patients detained under s. 3, there is no evidence to suggest any over-representation of people from particular minority ethnic backgrounds. However, based on the differences noted here, it would be unwise to conclude that any particular patient is more likely to be found in one group than in another. The structure of the MCA-DoLS data set severely limits the extent to which other factors can even begin to be examined.

4.3.3 *Care and treatment under the MCA-DOLS, for informal and for s. 3 detained patients*: a comparison of the duration of (i) MCA-DoLS authorisations resulting from applications by Managing Authorities based in PCTs, (ii) informal, and (iii) s.3 MHA detained patients provides a simple indicator of the experiences of individuals under each of the three legal frameworks. The findings are shown in Table 4.4.

Table 4.4: Duration of MCA-A DoLS authorisations, informal admissions, and detentions

		PCT	Informal	s3
		1,155	13,180	33,778
Duration in days of MCA-DoLS authorisations, informal admissions and s.3 detentions	1-90	76%	99%	31%
	91-180	14%	0%	19%
	181-270	5%	0%	33%
	271-364	2%	0%	7%
	365+	3%	0%	10%
	Not recorded	0%	0%	0%

Notes: a) through rounding up, the figures may not add up to 100%; b) the MHMDS data use every Year 2 care spell; c) it is worth noting that, overwhelmingly, informal admissions do not involve an overnight stay (44,626 admissions; 31,440 (70%) with no overnight stay). However, see footnote[84].

4.3.4 Table 4.4 appears to show that just over three-quarters of the MCA-DoLS authorisations are brief, lasting for between 1 and 90 days. The pattern most closely resembles that of informal admissions to psychiatric hospitals, most (90%) of which, if they last for more than one day, are for 1-90 days. In contrast, and, perhaps not

Team at the Health and Social Care Information Centre [personal email]. However, she notes that it is quite possible that some records of an admission of zero days may reflect missing data. At the time the data were collected, it was not possible to examine this issue further; however, data quality and completeness has improved in more recent versions of the MHMDS.

unexpectedly, given that s.3 is a 'treatment' section, most detentions are for longer than 1-90 days. However, the possible factors underlying these findings are uncertain. While they may reflect differences between the three legal frameworks, it is also possible that they relate to the demographic features of the patients in the groups (see Table 4.3), their clinical conditions, unknown or unmeasured factors, or perhaps a combination. Since we cannot explore these factors, the drawing of inferences about the implications for any one individual is unwarranted. We cannot say, for example, that any particular patient deprived or his or her liberty would *necessarily* be detained for a shorter period under s. 3 of the MHA.

4.3.5 The MCA-DoLS data set does not support further investigation into the 1-90 day period, so we cannot know whether the authorisations for a deprivation of liberty lasted closer to one, or to ninety days. In contrast, this information is available for informal admissions: for the minority admitted for more than one day, the average (median) duration is 19 days.

4.3.6 The national MCA-DoLS data set only provides information about *each* period of authorisation. It does not permit examination of the experiences of individuals who have been subject to the MCA-DoLS on more than one occasion in the year. Using the Forms from the three participating Supervisory Bodies, we examined the proportion of individuals who received an MCA-DoLS authorisation on at least one occasion. There were twenty relevant individuals. The data are summarised in Table 4.5.

Table 4.5: Number of separate authorisations of the MCA-DoLS

		DoLS authorisations
		20
No. of separate occasions on which the MCA-DoLS was authorised	1	80%
	2	15%
	3	0%
	4	5%
	5 or more	0%
	Missing	0%

Note: a) each individual can appear only once; b) the data do not support a comparison of transitions between the MCA-DoLS and the MHA, between informal and s.3 admissions, or the MCA-DoLS and informal admissions.

4.3.7 In our small sample, one in five individuals was subject to the MCA-DoLS on more than one occasion. While it is unlikely that the entire assessment was needed on each

occasion, because 'equivalent assessments' (Sch.A1, para. 49) are permitted, it can be seen that one person had four separate authorisations. These findings suggest that, for a considerable minority of individuals, relying only on the duration of each authorisation, rather than considering also the number of such authorisations, may lead to an inadequate appreciation of their experience of a deprivation of liberty.

4.4 The review process

4.4.1 Access to reviews is another indicator of the experiences of people subject to the MCA-DoLS. Table 4.6 compares reviews of the MCA-DoLS authorisations originating from PCTs with those from LAs.

Table 4.6: Reviews of MCA-DoLS authorisations

		PCT	LA
Number and proportion of authorisations reviewed:		473 (42%)	1,427 (37%)
Agency requesting review	Supervisory Body	33%	27%
	Person	0%	1%
	Relevant Person's Representative	4%	10%
	Managing Authority	63%	62%

4.4.2 Compared with authorisations originating from Managing Authorities in LAs, those from PCTs were *more* likely to be reviewed, *more* likely to take place at the request of the Supervisory Body, and *less* likely to be requested by a Relevant Person's Representative. Challenges made by individuals subject to the MCA-DoLS themselves were virtually non-existent, emphasising the need for a strong system for others to enforce safeguarding. While an automatic process of review forms part of the MHA, national information about reviews is not available through the MHMDS data set.

4.4.3 The interpretation of the findings related to reviews is problematic. First, it is not clear how a judgment might be reached about whether or not a given rate of review is acceptable or not. Secondly, there may be relationships between the likelihood of a review and factors such as the duration of a deprivation of liberty, the characteristics of the patient (age, clinical condition and so on) and the authorisation (e.g. geographical location). Unfortunately, no further investigations are possible at present because of the structure of the data set.

4.5 Summary

- The data available in the MCA-DoLS and MHA data sets are very limited, severely restricting the extent to which we were able to investigate the interface..

- Nevertheless, we were able to examine some aspects of the functioning of the MCA-DoLS. We found, for example, that applications to Supervisory Bodies made by Managing Authorities in services commissioned by PCTs differ slightly from those from local authorities. While the majority of applications from both PCTs and local authorities appear to be for people from a White British ethnic background, aged 65 years or more, and with dementia, those from PCTs are more ethnically and clinically diverse, and younger, group; they are also more likely to be men. People with learning disabilities form a small proportion of applications from both sources. The pattern of characteristics in the applications is reflected in the authorisations.

- Compared with informal or s. 3 detained patients in psychiatric hospitals, men and women people subject to the MCA-DoLS in general or psychiatric hospitals are more likely to be older and male. In contrast with detentions under s. 3, however, there appears to be no over- representation of people from minority ethnic backgrounds.

- From a small sample of standard Forms, it appears that one in every five men and women subject to the MCA-DoLS has experienced multiple authorisations in a one-year period. The current MCA-DoLS data set does not permit us to examine this issue in more detail in order to establish its possible significance.

- The available information does not allow us to establish whether there has been any move towards using the MCA-DoLS for patients who previously would have received care and treatment informally or under the MHA.

- Comparisons of the care and treatment received by men and women subject to the MCA- DoLS, or being treated in hospital informally under the MHA are very difficult to carry out and interpret: only information about the duration of a deprivation of liberty made following an application from a Managing Authority in a PCT, and the length of an informal admission, and of a s.3 detention is available; this is very crude.

- Comparisons between reviews of authorisations of the MCA-DoLS that follow

applications by Managing Authorities in PCTs and local authorities are also very difficult to carry out and interpret. From the available information, it appears that, compared with their counterparts in hospitals, slightly fewer men and women subject to the MCA-DoLS in services commissioned by the local authority are likely to have reviews of their deprivations of liberty, and that where such reviews do take place, they are more likely to be initiated by Relevant Person's Representatives. Almost no one subject to the MCA-DoLS initiates a review him or herself, highlighting the need for support for this vulnerable group of individuals.

CHAPTER 5: REFLECTIONS AND RECOMMENDATIONS

5.1 Introduction

5.1.1 The research brief invited us to examine practitioners' understanding of the interface between the MCA-DoLS and the MHA, and the characteristics of, and outcomes for, the patients affected by this interface. The study has focussed, therefore, on services (primarily psychiatric or general ('acute') hospitals) that, at the time, were commissioned by local PCTs, are normally registered for the use of the MHA, and are designed for the assessment and treatment of mental and/or physical disorders; we have not considered the use of the MCA-DoLS in care homes. Inevitably, however, while considering the interface between the MCA-DoLS and the MHA, we have been drawn into wider considerations relating to the procedure.

5.1.2 Our findings are presented and summarised in Chapters 3 and 4. In this Chapter, we reflect briefly on the findings before making our recommendations.

5.2 The achievements of the MCA-DoLS

5.2.1 Many of the participants in our study could be characterised as 'early adopters' of the MCA DoLS. This committed group, led primarily by representatives of the Supervisory Bodies, has established local structures and processes to promote the well-being of vulnerable men and women in psychiatric or general hospitals. Amongst all the many criticisms that the regulations and their accompanying procedure have generated, the significant achievements of these 'early adopters' in their implementation should not be overlooked. Moreover, while there remain many concerns, at least *some* practitioners, notably those with backgrounds in the MCA, feel that the MCA-DoLS provide a useful framework for protecting the rights of people who are vulnerable as a result of lacking capacity to make decisions about arrangements for their care and treatment.

5.2.2 From a broader perspective, the debate about the MCA-DoLS has made a useful contribution to discussions about the limits to freedom of movement that, within the framework provided by the ECHR, may lawfully be imposed on individuals with a 'mental disorder'. Those most often affected in hospital settings, as in care homes, are older people with dementia who have not committed, and are not even suspected of, any criminal offence, but simply lack capacity to make decisions about the

arrangements for their care and treatment. Such discussions should form part of the serious consideration that, in light of recent inquiries[85,86], is being given to the conditions under which services are being provided to patients in hospital settings, supposedly in their 'best interests'.

5.3 Concerns at the MCA-DoLS and MHA interface and beyond

5.3.1 Our findings suggest that the interface between the MCA-DoLS and the MHA is poorly understood by practitioners. We propose that there are two important conceptual reasons that may help to account for these findings. First, the principles and scope of, and criteria for, the MHA and the MCA are fundamentally different. While both pieces of legislation allow another person to make decisions on behalf of someone who would normally make that decision for him or herself, the MCA is based around principles of autonomy, empowerment, and the importance of supporting decision-making capacity as far as possible; the MHA is not. Secondly, there is limited appreciation of the role of the MCA and the MHA in allowing actions to be taken that would normally be seen as gross infringement of an adult's right to self-determination. The use of such legal frameworks must be transparent, justifiable, defensible, and open to challenge. It should be possible to read the application and assessment Forms relating to a particular patient, consult his or her care plan and understand how the relevant decisions were reached. Of course, there may be disagreement about these decisions but the discussion is only possible if the process of decision-making is clearly set out. In our view, both the conceptual differences between the MHA and the MCA and the failure to approach their use from a human rights perspective are central to understanding the difficulties that practitioners experience at their interface. These two issues underpin the most important of our recommendations.

5.3.2 Unfortunately, our findings suggest that there are difficulties that go beyond the interface between the MCA-DoLS and the MHA. We found considerable uncertainty among practitioners, including both clinicians and those with roles in making applications for, and carrying out, assessments regarding the meaning and interpretation of complex clinico-legal concepts. Such concepts include 'deprivation of

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85 Department of Health (2012). *Transforming care: a national response to Winterbourne View hospital*. London: Department of Health.

86 Francis, R. (Chair, 2013). *Independent inquiry into care provided by mid-Staffordshire NHS Foundation Trust*. London: The Stationery Office.

liberty' and 'purpose'. Verbal and physical challenges by patients and the use of restrictions by staff were used as indicators of a deprivation of liberty but, in the context of treatment of a mental disorder, the possibility that they signalled 'objection', suggesting consideration of the use of the MHA, was not always recognised. Operationally, the distinction between care and treatment and the arrangements for the provision of that care and treatment was poorly described; the possibility of less restrictive alternatives that could change a deprivation of liberty to restrictions was not appreciated fully; and the possibility of restraint, including restrictions to a patient's freedom under the strict conditions of s. 6 of the MCA, was not well understood. Practitioners complained that, while guidance is available, it is often unhelpful, out-of-date and/or its status is sometimes uncertain. We found the Forms to be rather unhelpful in guiding practitioners through the process of application and assessment and in providing an adequate basis for scrutiny and challenge.

5.3.3 The national data set provides information about the characteristics of patients for whom applications and authorisations are made under the MCA-DoLS. However, its current structure severely restricts the extent to which aspects of its use can be monitored. Comparisons between the characteristics and experiences of those subject to the MCA-DoLS, and patients who are admitted to psychiatric hospitals informally or detained under s.3 of the MHA, are limited by differences between the relevant data sets.

5.4 Recommendations

Recommendation 1: Strengthen attention to decision-making capacity in psychiatric as well as general hospitals

a) Capacity to consent to (i) the arrangements for providing care and treatment as well as (ii) the proposed plan of care and treatment should be assessed routinely for patients in psychiatric and general hospitals. While this assessment is not necessary for detention to take place under the MHA, an understanding of the extent to which a detained patient understands and can use information about all aspects of his or her care and treatment informs clinical practice and should be standard in all hospital settings. Even if someone lacks capacity to make relevant decisions and is detained under the MHA, the principles of promoting his or her participation in decision-making, as the MCA requires, should be seen as good practice. The outcome

of each assessment of capacity should be documented in the patient's care plan and kept under regular review by his or her clinical team.

b) Similarly, there should be an expectation that any restrictions on the freedom of movement of patients who lack capacity to consent to the arrangements for their care and treatment are documented in their care plans. The possibility that environmental changes could be made to limit the scope and extent of those restrictions should be reviewed regularly by the patient's clinical team.

c) Access to safeguards for informal patients in psychiatric hospitals who lack capacity to make decisions about arrangements for and/or elements of, their care and treatment needs to be enhanced. Given that decisions about these patients will be made under the legal framework provided by the MCA, we recommend that consideration is given to the extension of the role of IMCA to support these patients. As part of the role, an IMCA might usefully consider how the care and treatment of a patient who lacks capacity can best be provided in a way that does not amount to a deprivation of liberty unless such a deprivation is unequivocally in that person's best interests.

d) Information about the possibility, for patients who lack capacity, of restraint and restrictions under s. 6 of the MCA, providing that such limitations are necessary and proportionate, needs to be disseminated. Arrangements for carrying out this task will vary, but in some areas there are already Advisers available within Trusts or Supervisory Bodies who are well-placed to provide such information. For example, it should be explicitly stated in the care plan whether a patient is or is not to be allowed out of the ward, the conditions (for example, going alone or only with one or more members of staff) under which any absence from the ward is permitted, and the considerations that have led to the plan. Such detailed descriptions enable the balance between the patient's need for protection and his or her right to self-determination to be made explicit and challengeable.

Recommendation 2: Revise some of the standard Forms

It should be noted that the proposed changes to the MCA-DoLS Forms set out below are not necessarily specifically to the interface with the MHA. We believe that decision-making at this interface will, however, be improved if these changes are implemented.

a) *Form 4*: *Request for a Standard Authorisation*: consideration should be given to purpose of *Form 4*. If the aim is only to alert the Supervisory Body to the

possible need for the six assessments, then much of the detail currently required in Boxes B1, B2, and B3 (see Appendix IIIa) could be avoided.

b) Box A7 of the application Form, *Form 4*, should be amended to help practitioners understand the purpose for which the application is being made. The current wording is shown in Appendix IIIa. Possible wording is shown in Table 5.1.

Table 5.1: Possible wording for Box A7

What is it about the arrangements for this person's care and treatment that lead you to think that he or she might be deprived of his or her liberty? Please identify aspects of the care plan that involve any limitations to the person's freedom of movement.

c) The first part of Box B9 encourages practitioners to believe that they should be focussing on 'accommodation' rather than 'arrangements' (see *Form 4*, Appendix IIIa). A possible form of words is shown in Table 5.2 below.

Table 5.2: Possible wording for the first bullet point of Box B9

the person lacks capacity to make their own decision about the arrangements to provide them with the proposed care and/or treatment described above

d) Further amendments to Box B9 of *Form 4* may help practitioners describe why the person apparently needs to be deprived of his or her liberty. The current wording is shown in Appendix IIIa. We recommend that points a) – d) could be reduced, as suggested in Table 5.3 below.

Table 5.3: Possible wording for Box B9

Please: a) explain what alternative arrangements for providing this person's care and treatment in a way that might avoid a deprivation of his or her liberty have been considered. If any of these alternatives have been tried, please describe what and their outcome?. b) explain what harm the person is likely to come to in the absence of a deprivation of liberty and the likely seriousness of this harm

e) *Form 5: Age Assessment* (Appendix IIIb): to limit the administrative burden of the MCA-DoLS, consideration should be given to eliminating this Form and a slight extension of Part B of *Form 10*, the Best Interests Assessment (Appendix Bf), to include all the relevant information.

f) *Form 6*: *Mental Health Assessment*: it is uncertain whether the part of C3 (see Appendix IIIc) in which the Assessor is asked to consider the likely impact on the person's mental health of a deprivation of liberty plays any part in decision-making. Consideration should be given to deleting this part of *Form 6* (with a similar deletion from Box C2 of *Form 10*).

g) *Form 7: Capacity Assessment*: representatives of Supervisory Bodies have already identified problems in the standard version of *Form 7* (see Appendix IIId). In addition to changing the wording of Boxes C1 and C2 so that it reflects the arrangements made for the person rather than his or her accommodation, we recommend some additional questions. These are shown in Table 5.4 below.

Table 5.4: Possible additional questions and their wording

a) Please state what arrangements are being proposed for the patient's care and treatment ;
b) Please describe what practical steps that have been taken to help the patient make the decision about these arrangements for him or herself.
c) Please describe the patient's capacity to make a decision about the arrangements for his or her care in relation to his or her ability to a) understand information about the decision to be made; b) retain that information; c) use or weigh the information as part of the decision-making process; d) communicate his or her decision.

h) *Form 9*: *Eligibility Assessment*: Consideration should be given to the addition to *Form 9* (see Appendix IIIe) of a box asking the Eligibility Assessor to describe why the patient meets the criteria for detention in hospital under the MHA.

i) *Form 10*: *Best Interests Assessment*: Part C of *Form 10* (see Appendix IIIf) should be amended so that, in addition to giving the names and addresses of the individuals consulted, there is a requirement to provide (i) evidence of their views; (ii) information about the way in which their views have contributed to the Best Interest Assessor's decision-making.

j) The task of completing Box D5, (see Appendix IIIf), which asks Best Interests Assessors to give the reasons for their opinion as to whether or not the proposed arrangements constitute a deprivation of liberty, is demanding. The wording should be amended to help Best Interests Assessors distinguish a restriction from a deprivation of liberty. A possible form of words is shown in Table 5.5.

Table 5.5: Possible wording for Box D5

a) What aspects of the proposed arrangements for the person's care and treatment involve placing restrictions on his or her liberty? b) What is it about these arrangements that, in your opinion, amounts to a deprivation of liberty?

k) We recommend that extensive amendments are made to Part D (see Appendix IIIf) so that it is clear: (i) what the proposed arrangements for the provision of the patient's care and treatment comprise; (ii) the reason that these arrangements are thought to constitute a deprivation of liberty; (iii) the nature and extent of the harms to the patient that are expected to be prevented by a deprivation of his or her liberty; (iv) the nature of any less restrictive arrangements that are available in the person's current environment and the extent to which these have been considered and tried; (iv) the contribution to the Best Interests Assessor's decision-making of the patient him or herself as well as each 'interested person' who has been consulted; and (v) why a deprivation is to be considered in the patient's best interests.

l) *General considerations*: (i) where relevant, the design of the Forms needs to be amended so that free text boxes are expandable rather than requiring the use of continuation sheets; (ii) any revisions to the wording of the Forms should be checked to ensure that they meet the criteria for clarity required for the Plain English Campaign's Crystal Mark seal of approval (http://www.plainenglish.co.uk); (iii) the development of any revisions of the Forms should involve, and include piloting with, the practitioners who will complete them; (iv) since completion of the Forms can be challenging, particularly for those who do not have ready access to local 'Advisers', the use of 'good practice' exemplars should be included in the should be disseminated through a national website.

Recommendation 3: Revise and update the MCA-DoLS Code of Practice and clarify the status of guidance issued by the Department of Health

a) There is a need for further guidance in the Code of Practice, relating to (i) the importance of a culture that attempts to prevent deprivations of liberty, through, for example, holding multi- disciplinary meetings (similar to the 'best interests' meetings

that take place in making decisions on behalf of a person who lacks capacity to make the decision for him or herself) before requesting an assessment of a Standard Authorisation. The aim of this meeting, which should be recorded in the patient's care plan should be to consider how best to maintain the patient's freedom of movement; (ii) the possibility, for patients who lack capacity, of restraint and restrictions under s. 6 of the MCA providing that such limitations are necessary and proportionate, and the importance of documenting their duration, purpose, attempts to employ other strategies and their impact, and so on; (iii) an up-to-date list of factors that *may* suggest a deprivation of liberty, with examples to demonstrate that it is not the 'nature and substance' but the 'intensity and degree' of the restriction that is important.

b) Extensive changes will be needed to the text of the CoP[87], Annexes 1 and 2, and Ch. 13 of the Code of Practice of the MCA. We recommend that the MCA-DoLS CoP be incorporated into the Code of Practice for the MCA, but if this is considered too costly, its relationship with the parent legislation needs to be much clearer. At the least, the principles of the MCA need to be set out. We do not think that any changes are needed to the MHA's Code of Practice, but it would be helpful to consult practitioners to minimise the possibility that the guidance appears inconsistent.

c) Further clinical examples, capturing the complexity of the situations encountered by practitioners, should be included. These should relate both to the interface between the MHA and the MCA-DoLS, and also to the interfaces between the MCA, the MHA, and other relevant policy and legislation. Consideration should be given to the presentation of 'good practice' in relation to the groups whom we believe may be at particular risk of deprivations of their liberty going unrecognised. These are (i) men and women who lack capacity, are compliant, and receive treatment as informal psychiatric hospital patients; (ii) general hospital patients who are deprived of their liberty but whose lack of relevant decision-making capacity is not identified.

d) While we recognise the demands that revisions to the Code of Practice and amendments to the standard Forms will place on those involved, we believe that the importance of including a broad range of stakeholders, including clinicians in general and psychiatric hospitals and their professional bodies, carers, and practitioners with formal roles in the MCA-DoLS process cannot be over-stated.

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[87] Ministry of Justice (2008), *op. cit.*, n. 15.

e) If, following decisions by the court, guidance about the use of the MCA-DoLS is to be issued by the Department of Health, then there needs to be clarity for practitioners at all levels regarding whether it provides 'good practice' guidance or is mandatory.

Recommendation 4: Review and improve the data collection and monitoring procedures

a) From 1st April, 2013, the MCA-DoLS procedure has been supervised by local authorities. The impact of the loss of information from services commissioned by PCTs could, with little effort, be alleviated if the Health and Social Care Information Centre (HSCIC) distinguished data from hospitals and care homes. A better solution, however, and one which we very strongly recommend, is that individual level, rather than aggregated, data are collected. For each application, the setting in which the deprivation of liberty for which authorisation is sought (for example: care home, general hospital, psychiatric hospital) should be recorded.

b) If individual case level data were collected, Supervisory Bodies could pass discrete details about each application and authorisation to the HSCIC. The effect would be that the MCA-DoLS data collection would resemble more closely the structure of the Mental Health Minimum Data Set (MHMDS). Ideally, applications and authorisations should be linked, perhaps by the use of an anonymous personal identifier.

c) Consideration should also be given to ways of linking the MHMDS with the data set for the MCA-DoLS to support monitoring of applications for, and authorisations of, the use of the procedure in psychiatric hospitals. This would be much more easily achievable with the collection of individual case level data.

d) Currently, the only information recorded about reviews under the MCA-DoLS relates to the person making the request. Such information enables the rate of reviews to be calculated, but, even with data collection at an individual level, this is of limited interest; we recommend that the *outcome* of reviews should be recorded as well. We also recommend that, in discussion with practitioners and the HSCIC, consideration should be given to other aspects of reviews that are believed to be of importance and the ways in which the necessary data might be collected and analysed.

e) With the exception of d), which was a later consideration, we have submitted the proposals in Recommendation 4 to a recent consultation carried out by the HSCIC on the collection of adult social care data[88,89]. While the responses are in the process of being reported[90], early indications suggest that our proposals have been accepted and may be implemented for 2013/14[91,92]. The latest information on changes to the MCA-DoLS data collection can be found at http://www. hscic/article/2458/Collections-development.

88 Health and Social Care Information Centre (2012a). *Consultation on Adult Social Care Data Developments: 2012*. Leeds: The Health and Social Care Information Centre. Available at: http://www.hscic.gov.uk/media/9756/2-Consultation-on-Adult-Social-Care-Data-Developments-2012-Main-Consultation-Document/pdf/2_Consultation_Main_consultation_doc.pdf.

89 Wagner, A. P., Holland, A. J., Redley, M., Clare, I. C. H. (2012). Response to Consultation on Adult Social Care National Data Developments 2012. Cambridge: University of Cambridge. Available from: apw40@medschl.cam.ac.uk.

90 *Health and Social Care Information* Centre (2012b). *Responses to the Consultation Adult Social Care Data Developments 2012*. Leeds: The Health and Social Care Information Centre. Available at: http://www.hscic.gov.uk/media/10088/Consultation-Summary/pdf/00_Consultation_report.pdf.

91 Health and Social Care Information Centre (2012c). *Letter to social services dated 28th September 2012*. Leeds: The Health and Social Care Information Centre. Available at: http://www.hscic.gov.uk/media/10454/Letter-to-social-services-dated-28th-September-2012/pdf/September_Letter_2012_final.pdf.

92 Health and Social Care Information Centre (2012d). *Adult Social Care National Data Collections Safeguarding Collections 2013/2014*. Leeds: The Health and Social Care Information Centre. Available at: http://www.hscic.gov.uk/media/10455/Letter-to-social-services-dated-28th-September-2012---Appendix-4-Adult-Safeguarding-Return/pdf/Safeguarding_document_for_Sept_letter.pdf.

CHAPTER 6: FURTHER RESEARCH, AND DISSEMINATION

In this Chapter, we first make suggestions for further research, and then set out the dissemination of the study that has already taken place and is planned.

6.1 Further research

6.1.1 *The experiences of men and women subject to the MCA-DoLS in hospital and their Relevant Person's Representatives*: while our study focussed on practitioners ('professionals'), there is an obvious need to explore the experiences of men and women who are or have been subject to the MCA-DoLS in hospital and their Relevant Person Representatives. Longitudinal 'tracking' of the outcomes for these individuals (their experiences of reviews, and so on) would also be very useful. Our experiences during the research study indicated that it will not be easy to access people in hospital, or their carers, to invite them to participate. Access may best be achieved by a collaboration of clinical researchers who are employed by, or hold Honorary Contracts with, the NHS Trusts in which the research is to be carried out. The collection of quantitative data to support this study will be possible if the changes to the MCA-DoLS data set that we have recommended (Recommendation 4) take place. In addition, the potential exists to use the data linkage services of the HSCIC[93] to investigate the occurrence of people subject to the MCA-DoLS who are reported in other data sets collected by the HSCIC (such as the MHMDS, or perhaps the Hospital Episode Statistics (HES), a dataset containing the records of all patients admitted to NHS hospitals in England[94]). However, this potential will only be fulfilled once the MCA-DoLS data set becomes an individual level collection, and further developments take place in the data linkage services at the HSCIC[95].

6.1.2 *Regional and local variations in the use of the MCA-DoLS and the MHA*: there is undoubtedly scope for further research into regional variations in the use of the MCA-DoLS. While it is likely that other factors may be involved, data from the KP90 (another

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[93] Health and Social Care Information Centre (2013a). Data linkage services. [online] Available at: http://www.ic.nhs.uk/datalinkage.

[94] Health and Social Care Information Centre (2013b). *Hospital Episode Statistics*. [online] Available at: http://www.ic.nhs.uk/hes.

[95] Significant developments are happening at the HSCIC which will dramatically increase their ability to link data sets. The latest information can be found on their website; for example: Health and Social Care Information Centre (2013c). Data Linkage Service Stakeholder Forum. [online] Available at: http://www.hscic.gov.uk/article/2469/Data-Linkage-Stakeholder-Forum---19-March-2013.

MHA database, see Appendix II) suggests the *possibility* of a relationship between rates of detention under the MHA and use of the MCA-DoLS. For example, from the KP90 return for 2010/2011, two regions (London and the North West) with the highest rates of admissions under the MHA had among the lowest rates of MCA-DoLS applications. Whether such a relationship exists, and the possible reasons, will contribute to our understanding of the way in which the two Acts are being used. In addition, and perhaps more importantly, much more needs to be known about practice in those general and psychiatric hospitals with differing rates of applications. There is an urgent need to examine and understand local differences in practice in order to understand how best to support the use of the MCA-DoLS where it is appropriate.

6.1.3 *Investigating the MCA-DoLS review procedure*: rightly, since a deprivation of liberty engages Article 5 (4) of the ECHR, there is concern about access to reviews of authorisations for deprivations of liberty under the MCA-DoLS. The paucity of information about the review process demands further research. Quantitative research might both focus on the identification of metrics that the HSCIC could collect to monitor the process and try to develop a consensus about the meaning of different rates of review. Qualitative research might use case studies to investigate the review process in detail.

6.2 Dissemination

6.2.1 We have already presented aspects of the findings at presentations for practitioners and academic researchers:

a) Holland, A.J., Bagnoli, A. and Keeling, A. (2010). The Interface between the MHA and the MCA DoLS. Joint presentation and discussion at the 8th National Old Age Psychiatry Advanced Trainees' Residential Conference, Cambridge, 18th November.

b) Bagnoli, A., Keeling, A., Redley, M., Holland, A.J., Gunn, M., Thompson, F. and Clare, I.C.H. (2011). Applications for Deprivation of Liberty Safeguards authorisations: practitioners' decisions and the everyday practice of form-filling. Presentation by A. Bagnoli at the Socio-Legal Studies Association Annual Conference, Brighton, 12-14th April.

c) Keeling, A., Gunn, M., Bagnoli, A., Holland, A.J., Redley, M., Thompson, F. and Clare, I.C.H. (2011). Challenges in determining deprivations of liberty for adults who lack capacity Presentation by A. Keeling at the Socio-Legal Studies Association Annual Conference, Brighton, 12-14th April.

d) Keeling, A., Gunn, M., Bagnoli, A., Holland, A.J., Redley, M., Thompson, F. and Clare, I.C.H. (2011). The challenge of 'necessary restrictions' in determining deprivation of liberty for adults who lack capacity. Presentation by A. Keeling at the Royal College of Psychiatrists' International Congress, Brighton, 29th June.

e) Clare, I.C.H., Bagnoli, A., Keeling, A., Redley, M. and Holland, A.J. (2011). Deciding between the MCA DoLS and the Mental Health Act in England & Wales: Just a matter of choice? Presentation by I.C.H. Clare at the XXXII[nd] International Congress of the International Academy of Law and Mental Health, Berlin, 17-23rd July.

f) Holland, A.J., Redley, M., Keeling, A., Wagner, A.P., Wheeler, J., Bagnoli, A., Gunn, M., Thompson, F. and Clare, I.C.H. (2011). The MCA Deprivation of Liberty Safeguards & the Mental Health Act: A matter of choice?, Department of Health Consultation and Dissemination Event, London, 21st November.

g) Clare, I.C.H., Redley, M., Keeling, A., Wagner, A. P., Wheeler, J., Holland, A.J. and Gunn, M. (2012). Understanding the interface between the MCA-DoLS and the MHA. Presentation at the Department of Health's Mental Health Act Research Roundtable Meeting, London, 12th December.

h) Clare, I.C.H, Holland, A. J., Keeling, A., Gunn, M. and Redley, M. (2013). Restriction, Deprivation, and Detention: Limits to freedom within English mental health and mental capacity legislation. Abstract accepted for the XXXIII International Congress of the International Academy of Law and Mental Health, Amsterdam, 14-19th July.

6.2.2 In addition, experience of working with the MCA-DoLS data set led to:

Wagner, A.P.,Holland, A.J., Redley, M. and Clare, I.C.H. (2012). *Response to Consultation on Adult Social Care National Data Developments*.

6.2.3 The following further dissemination activities are planned:

a) A paper about the study to be submitted to a peer-reviewed academic journal.

b) A paper in Advances in Psychiatric Treatment, a practitioner journal for psychiatrists, published by the Royal College of Psychiatrists.

c) A briefing paper outlining the findings and their implications for 'good practice' for all those who contributed to the data collection. We will disseminate this paper through our website, and through resources such as Mental Health Law Online (discussion@mentalhealthlaw.co.uk), and the specialist Mental Capacity Act/Mental Health Act website (http://www.davesheppard.co.uk).

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APPENDICES

Appendix I: Project Advisory Group

Members of the DoLS Project Advisory Group from June 2010-Dec 2011

Name	Role	Organisation
Ms Alison Cobb	Policy and Campaigns Manager (Mental Health Services)	MIND
Dr Tom Dening	Medical Director; Consultant Psychiatrist, Older People's Services,	Cambridgeshire and Peterborough NHS Foundation Trust
Ms Emma Ekwegh	MCA Deprivation of Liberty Safeguards (DoLS) Service Coordinator	London Borough of Lambeth
Mr Paul Gantley OBE	National Implementation Manager, MCA (retired 2010)	Department of Health
Mr Mark Hall	Service Development Manager, Specialist Services Devision	Cambridgeshire and Peterborough NHS Foundation Trust
Ms Gemma Honeyman	Family Support Policy Manager	Challenging Behaviour Foundation
Dr Fiona Thompson	Consultant Psychiatrist, Older People's Services	Cambridgeshire and Peterborough NHS Foundation Trust
Mr Stephen Vickers	Deprivation of Liberty Team Manager	Leicester, Leicestershire and Rutland MCA-DoLS Service
Ms Frances Wellburn	Assistant Director for Performance and Safeguarding	NHS Lambeth
Mr Toby Williamson	Head of Development and Later Life	Mental Health Foundation
Mr Joseph Yow	MCA-DoLS Lead for Cambridgeshire	Cambridgeshire County Council

Appendix II: The recording of information about the use of the Mental Health Act: the use of the Mental Health Minimum Data Set (MHMDS)

A2.1 Choosing a database

A2.1.1 The Mental Health Minimum Data Set (MHMDS) was established `to facilitate the collection of person focused clinical data and the sharing of such data to underpin the delivery of mental health care'[96], and is utilised to record information about the use of the Mental Health Act, together with a wide range of other information[97]. The KP90, which has been in operation for longer, is also used to record this information[98]. Following a public consultation, the results of which are still to be published in full, it is possible that a recommendation will be made that the KP90 will be replaced by the MHMDS, subject to it being able to provide the same scope, and quality, of data [99,100].

A2.1.2 There is a major, and very important, difference between the KP90 and the MHMDS: the KP90 records *the number of uses* of the MHA for a single individual within a year, separately counting each *detention*, regardless of whether that detention is under the same, or a different section. In contrast, the MHMDS records the *number of individuals* subject to the MHA in any year. Separate detentions for the same person can be linked, so that multiple uses of the MHA for him or her are only counted once[101,102]. Since the numbers relate to different quantities, the different systems report different numbers[103].

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96 Health and Social Care Information Centre (2008b). National Datasets Service. *DRAFT Mental Health Minimum Dataset (MHMDS) v3.0 Specification and Guidance*, p7. Leeds: The NHS Information Centre. Available at: http://www.isb.nhs.uk/documents/isb-0011/dscn-06-2008/011062008specification.pdf.

97 Health and Social Care Information Centre (2008b), *ibid.*

98 Health and Social Care Information Centre (2013d). *Admissions, Changes in Status and Detentions under the Mental Health Act Collection – Health & Social Care Information Centre*. [online] Available at: http://www.ic.nhs.uk/datacollections/kp90.

99 Health and Social Care Information Centre (2012e). *Mental Health Act Statistics consultation*. [online] Available at: http://www.hscic.gov.uk/MentalHealthAct_stats_consultation.

100 Health and Social Care Information Centre, Community and Mental Health Team (2012). *Responses to the Consultation on Mental Health Act Statistics*. Leeds: The Health and Social Care Information Centre. Available from: http://www.ic.nhs.uk/CHttpHandler.ashx?id=10072&p=0.

101 Health and Social Care Information Centre (2008b), *op. cit.*, n. 96.

102 Health and Social Care Information Centre (2012e), *op. cit*., n. 99.

103 Health and Social Care Information Centre (2011c). *The NHS Information Centre: Mental Health Minimum Dataset: FAQs*. [online]. Available at: http://www.mhmdsonline.ic.nhs.uk/faqs/#different.

A2.1.3 The demographic data available in the KP90 data are limited to gender[104]. Since, for this study, we sought more detailed demographic information, together with additional information relating to, for example, the duration of detentions, we used the MHMDS.

A2.1.4 However, a limitation of the MHMDS is that figures about the use of the MHA are not collected from services that are designated for people with learning (intellectual) disabilities. Information about men and women with learning disabilities is only included if they are receiving assessment or treatment from mental health services for other groups (for example, general psychiatry services). Discussions with the HSCIC have suggested that future versions of the MHMDS will collect information from designated learning disability services.

A2.2 Comparing data from the MHMDS with that from the MCA-DoLS data set

A2.2.1 A subset of the MHMDS needed to be chosen so that the characteristics of individuals who might be detained under the MHA could be compared with those of men and women who are subject to the MCA-DoLS. Unfortunately, there is no suitable variable such as, for example, whether or not the person has capacity to consent to the arrangements for their care and treatment. This means that the comparison groups are approximate. Given that s. 2 is *normally* (but see s.4, MHA) applied for no more than 28 days, and is intended for the purpose of assessment, rather than treatment, we decided, in discussion with members of our Advisory Group, that reasonable approximate comparison groups would be individuals detained in hospital for treatment under s. 3 of the MHA, and those admitted under common law (informally) for assessment and/or treatment of their mental health difficulties.

A2.2.2 In the MHMDS (v3.0 – the version available when the research was carried out[105]), the basic unit of data is the `Mental Health Care Spell' or `care spell'. This is 'a continuous period of care or assessment for an adult (including elderly) Patient provided by a Health Care Provider's specialist mental health services or Local Authority's Social Services'[106]. Each care spell recorded in the database includes demographic details about the patient and a summary of the care or assessment that he or she receives. In addition, each patient has a unique identifier that allows care

[104] NHS Data Model and Dictionary Service (2010). *Data Set: Patients Detained In Hospital Or On Supervised Community Treatment Data Set (KP90)*. [online] Available at: http://www.datadictionary.nhs.uk/data_dictionary/messages/central_return_data_sets/data_sets/patients_detained_in_hospital_or_on_supervised_community_treatment_data_set_%28kp90%29.asp.

[105] The latest developments of the MHMDS can be found at: http://www.ic.nhs.uk/mhmds/spec.

[106] Health and Social Care Information Centre (2008b), *op. cit.*, n. 96, p. 15.

spells for the same person to be linked, addressing the problem of `double counting' present in the MCA-DoLS data collection and discussed in Chapter 4.1.4.

A2.2.3 The research team made an application, approved by the Data Access Advisory Group of the Health and Social Care Information Centre, for an extract from the MHMDS that is not routinely made available to the public. The data for each care spell included, but was not limited to, the patient's:

1. unique identifier;
2. gender;
3. age;
4. ethnicity;
5. the highest level of legal restrictiveness experienced during the current year[107];
6. the number of days in the care spell for which the patient was formally detained;
7. and the number of days in the care spell that the patient spent on a ward (excluding time in 'medium or intensive care wards').

The MHMDS does not record details of religion or belief, sexual orientation and very little about disabilities, limiting the comparisons that could be made with the MCA-DoLS dataset.

A2.2.4 Using the chosen fields from the MHMDS, informal and s. 3 groups were created, subject to the following constraints[108]:

- Informal admissions – each patient:
  - is only counted once;
  - is an adult (18+);
  - has spent one or more nights in a setting in which the MHA could be used;
  - has not experienced a legally more restrictive period of formal detention during the same year[109].
- s3 detentions – each patient:

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[107] Health and Social Care Information Centre (2008b), *op. cit.*, n. 96, p. 147.

[108] The approach that we have adopted is somewhat different to the methodology used to produce the figures given in the Annual report for 2010/2011 (NHS Information Centre, Mental Health and Community Team (2011a). *Mental Health Bulletin Fifth report from Mental Health Minimum Dataset (MHMDS) annual returns, 2011*. Leeds: The Health and Social Care Information Centre. Available at: https://catalogue.ic.nhs.uk/publications/mental-health/services/ment-heal-bull-mhmds-anua-retu-2011/ment-heal-bull-mhmds-anua-retu-2011-rep.pdf). Differences between the figures in this report and the HSISC's Annual Report are therefore to be expected. The approaches are very similar, however, in that we too have attempted to select the most restrictive care spell for each person (NHS Information Centre, Mental Health and Community Team (2011b). *Mental Health Bulletin Fifth report from Mental Health Minimum Dataset (MHMDS) annual returns, 2011: Data quality and methodology report*. Leeds: The Health and Social Care Information Centre. Available at: http://www.ic.nhs.uk/catalogue/PUB02988/ment-heal-bull-mhmds-anua-retu-2011-meth.pdf).

[109] Health and Social Care Information Centre (2008b), *op. cit,* n. 96, p. 147.

- is only counted once;
- is an adult (18+);
- has spent one or more days detained under the MHA;
- has not experienced a legally *more* restrictive period of detention during the year (such as a s. 37), but *may* have experienced detention that is less restrictive[110].

The legal restrictiveness conditions are enforced so that:

- a patient who is admitted informally admitted at some point, but experiences any form of detention under the MHA at some other time in the year will be excluded from the informal admissions group;
- a patient who is detained under s. 3, but experiences a more restrictive form of detention at some other time in the year will be excluded from the s. 3 group.

[110] Health and Social Care Information Centre (2008b), *Ibid,* p. 147.

Appendix III: MCA-DoLS Standard Forms

Appendix No	Form. No	Title
Appendix IIIa	4	Request for a Standard Authorisation
Appendix IIIb	5	Age Assessment
Appendix IIIc	6	Mental Health Assessment
Appendix IIId	7	Mental Capacity Assessment
Appendix IIIe	9	Eligibility Assessment
Appendix IIIf	10	Best Interests Assessment

Appendix IIIa: *Form 4 - Request for a Standard Authorisation*

CASE NUMBER

Mental Capacity Act 2005

DEPRIVATION OF LIBERTY FORM No. 4

REQUEST FOR A STANDARD AUTHORISATION

Important notes: Regulation 16 of The Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008 (SI 2008 No. 1858) contains requirements about the information to be provided in a request for a standard deprivation of liberty authorisation.

Regulation 16 states that the information in Part A of this form must be included in every request for a standard authorisation.

The information in Part B should be provided if it is available to, or could reasonably be obtained by, the managing authority. The information in Part B does not need to be re-provided in cases where there is already an existing standard authorisation if that information remains the same as supplied with the request for the earlier authorisation. However, this does not apply to the information about an existing authorisation covered in box B14 of this form.

Part C covers further information that might helpfully be provided by the managing authority.

The supervisory body should ensure that each assessor, and any instructed IMCA, receives a copy of this form as soon as possible.

PART A — INFORMATION THAT MUST BE PROVIDED

A1	Full name of the person who needs to be deprived of their liberty in this hospital or care home	Name	
A2	Their gender	Male ☐	Female ☐
A3	Their date of birth (or estimated age if unknown)	DOB	
		Est. Age	Years
	The age range within which the person falls	**Place a cross in ONE of the boxes below ➢**	
	18–64	☐	
	65–74	☐	
	75–84	☐	
	85+	☐	

1

A4	The person's current location (Place a cross in one box, and then enter the current location) ⇉	Already in this hospital or care home ☐
		Currently at their own private address ☐
		Currently in another hospital or care home ☐
		Other (please specify):
		Current location (address)
		Post Code
		Telephone
A5	Name and address of the person registered, or required to be registered, under Chapter 2 of Part 1 of the Health and Social Care Act 2008 in respect of the provision of residential accommodation, together with nursing or personal care, in the care home and in relation to an independent hospital, the person registered, or required to be registered, under Chapter 2 of Part 1 of the Health and Social Care Act 2008 in respect of regulated activities (within the meaning of that Part) carried on in the hospital, or the NHS Trust that manages the hospital	Name
		Address
		Postcode
		Telephone
A6	Person to contact at the hospital or care home	Name
		Email
		Telephone

A7 THE PURPOSE FOR WHICH THE AUTHORISATION IS REQUESTED

The purpose for which this standard authorisation is requested should be described here.

Note: there is a legal requirement that the giving of a Mental Capacity Act 2005 deprivation of liberty safeguards authorisation must be for the purpose of giving care or treatment to the person to whom the authorisation relates. The entry below should therefore identify the care and/or treatment that constitutes the purpose for which the authorisation is given. It should be borne in mind, however, that the deprivation of liberty authorisation does not itself authorise the care or treatment concerned, the giving of which is subject to the wider provisions of the Mental Capacity Act 2005.

The purpose of the requested standard authorisation is to enable the person to be given the following care and/or treatment in this hospital or care home.

Please Use Continuation Sheet

A8 THE DATE FROM WHICH THE STANDARD AUTHORISATION IS SOUGHT		
The standard authorisation is required to start on this date:		
This is because:		
	Place a cross in ONE of the boxes below ➢	
A	The existing urgent authorisation expires at that time.	☐
B	The existing standard authorisation expires at that time.	☐
C	The existing order of the Court of Protection expires at that time.	☐
D	We expect to receive the person in this hospital or care home at that time, and it is likely that we will need to deprive them of their liberty immediately.	☐
E	None of the above applies. However, it is likely that the person will need to be deprived of their liberty and will meet all of the requirements for a standard authorisation at that time.	☐

3

A9 HAS THE MANAGING AUTHORITY GIVEN AN URGENT AUTHORISATION? [Yes] ☐ [No] ☐

If yes, please enter the date on which it expires: d d m m y y y y

PART B – OTHER INFORMATION THAT SHOULD BE PROVIDED IF IT IS AVAILABLE TO, OR COULD REASONABLY BE OBTAINED BY, THE MANAGING AUTHORITY, UNLESS IT HAS BEEN PREVIOUSLY PROVIDED IN RESPECT OF AN EXISTING STANDARD AUTHORISATION AND THAT INFORMATION REMAINS THE SAME

Note: this 'previously provided' exemption does not apply to the information about an existing authorisation covered in box B14 of this form.

B1	**RELEVANT MEDICAL INFORMATION** Medical information relating to the person's health that the managing authority considers to be relevant to the proposed restrictions to the person's liberty: Please Use Continuation Sheet
B2	**DIAGNOSIS OF THE MENTAL DISORDER** Diagnosis of the mental disorder (within the meaning of the Mental Health Act 1983[1], but disregarding any exclusion for persons with learning disability) that the person is suffering from: Please Use Continuation Sheet
B3	**RELEVANT CARE PLANS OR NEEDS ASSESSMENTS** The following relevant care plans and/or needs assessments are attached: Please Use Continuation Sheet

B4 RACIAL, ETHNIC OR NATIONAL ORIGIN

The person's racial, ethnic or national origin

Place a cross in ONE of the boxes below ➢

White		
A	British	☐
B	Irish	☐
C	Any other White background (to include Travellers of Irish heritage and Gypsy/Roma)	☐
D	White and Black Caribbean	☐

1 References in this form to provisions of the Mental Health Act 1983 include provisions of other enactments that have the same effect.

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Mixed OR Mixed British		
E	White and Black African	☐
F	White and Asian	☐
G	Any other mixed background	☐
Asian OR Asian British		
H	Indian	☐
J	Pakistani	☐
K	Bangladeshi	☐
L	Any other Asian background	☐
Black OR Black British		
M	Caribbean	☐
N	African	☐
P	Any other Black background	☐
Other ethnic groups		
R	Chinese	☐
S	Any other ethnic group	☐
Z	Not stated (to include cases in which the person has refused to divulge their ethnic origin or where their ethnic origin is not yet known)	☐

B5 THE PERSON'S RELIGION OR BELIEF **Place a cross in ONE of the boxes below➢**	
	None ☐
	Christian (Christian includes Church of Wales, Catholic, Protestant and all other Christian denominations) ☐
	Buddhist ☐
	Hindu ☐
	Jewish ☐
	Muslim ☐
	Sikh ☐
	Any other religion ☐
	Not stated ☐

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B6 THE PERSON'S SEXUAL ORIENTATION

Place a cross in ONE of the boxes below ➢

Heterosexual	☐
Lesbian or gay	☐
Bisexual	☐
Other	☐
Prefer not to say	☐
Not known	☐

B7 THE PERSON'S DISABILITY – i.e. THE DISABILITY THAT IS CAUSING THEIR CURRENT INCAPACITY
Place a cross (or crosses) as applicable in only one of A OR B OR C

A **Place a cross in EACH of the boxes below that apply ➢**

Physical disability, frailty and/or sensory impairment ☐

Please identify which of the following apply:

- Physical disability, frailty and/or temporary illness ☐
- Hearing impairment ☐
- Visual Impairment ☐
- Dual sensory loss ☐

B Mental Health ☐

Please also place a cross in this box if the Mental Health condition is dementia ☐

C Learning disability ☐

B8 WHETHER THE PERSON HAS A PREFERRED COMMUNICATION OR A PREFERRED FIRST LANGUAGE

Place a cross in one box ⮒ No ☐ Yes ☐

If yes, describe them, e.g. interpreter required (specify language), BSL signer required, etc.

B9 WHY THE PERSON NEEDS TO BE DEPRIVED OF THEIR LIBERTY

In our opinion:

- the person lacks capacity to make their own decision about whether to be accommodated here for the purpose of being given the proposed care and/or treatment described above
- it is in their best interests to be deprived of their liberty here so that they can be given this care and/ or treatment
- this is necessary in order to prevent harm to them, and it is a proportionate response to the harm they are likely to suffer if they are not so deprived of liberty, and the seriousness of that harm.

Explain here:

(a) the nature of the restrictions on the person's liberty that lead to the conclusion that they are, or will be, deprived of their liberty;

(b) why the necessary care and/or treatment cannot be provided in a way that is less restrictive of the person's rights and freedom of action;

(c) to the extent that the managing authority is aware, what alternatives to deprivation of liberty have been considered;

(d) what harm the person is likely to come to if they are not deprived of their liberty in this hospital or care home.

Please Use Continuation Sheet

7

B10 WHETHER IT IS NECESSARY FOR AN INDEPENDENT MENTAL CAPACITY ADVOCATE (IMCA) TO BE INSTRUCTED		
	Place a cross in ONE of the boxes below (A or B) ➢	
A	Apart from professionals and other people who are paid to provide care or treatment, this person has no one whom it is appropriate to consult about what is in their best interests. If the person has no relevant person's representative, or this is a request for a first standard authorisation, the supervisory body must therefore instruct an IMCA to support and represent them.	☐
B	There is someone whom it is appropriate to consult about what is in this person's best interests who is neither a professional nor is being paid to provide care or treatment.	☐

B11 WHETHER THERE IS A VALID AND APPLICABLE ADVANCE DECISION		
	Place a cross in box A, B or C below ➢	
A	The person has made an advance decision that may be valid and applicable to some or all of the treatment.	☐
B	The managing authority is not aware that the person has made an advance decision that may be valid and applicable to some or all of the treatment.	☐
C	The proposed deprivation of liberty is not for the purpose of giving treatment.	☐

B12 THE PERSON IS SUBJECT TO THE FOLLOWING MENTAL HEALTH ACT 1983 REGIMES		
	(The hospital treatment, community treatment and guardianship regimes are defined in paragraphs 8 to 10 of Part 2 of Schedule 1A to the Mental Capacity Act 2005.) **Place a cross in box A, B or C below if any of those options apply, otherwise leave the boxes blank ➢**	
A	Hospital treatment regime	☐
B	Community treatment regime	☐
C	Guardianship regime	☐

B13 INFORMATION ABOUT INTERESTED PERSONS Please continue on a separate sheet if necessary.		
Anyone named by the person as someone to be consulted about their welfare	Name	
	Address	
	Telephone	
Anyone engaged in caring for the person or interested in their welfare	Name	
	Address	
	Telephone	
Any donee of a lasting power of attorney granted by the person	Name	
	Address	
	Telephone	
Any deputy appointed for the person by the Court of Protection	Name	
	Address	
	Telephone	
Any IMCA instructed in accordance with sections 37 to 39D of the Mental Capacity Act 2005	Name	
	Address	
	Telephone	

B14 IS THERE AN EXISTING STANDARD AUTHORISATION IN RELATION TO THE DEPRIVATION OF LIBERTY OF THE RELEVANT PERSON		**Place a cross in box A or B ➢**
A	There is an existing standard authorisation in relation to the person to be deprived of liberty. The authorisation expires on: _____ **Fill in the expiry date above ≤**	☐

B	The managing authority is not aware of any existing standard authorisation in relation to the person to be deprived of liberty.		☐
PART C – FURTHER INFORMATION		**Place a cross in one of these three boxes ➢**	
C1	The address where the person ordinarily resides	The address given in box A4 above where the person currently is	☐
		The person was of no fixed abode	☐
		The following address, at which the person is ordinarily resident:	☐
		Address	
C2	The name of the individual who is considered to be the person most closely involved in looking after the person's welfare.	Name	
		Relationship	
		Address	
		Telephone	
C3	Name of the PCT or local authority to whom this form is being sent ('the supervisory body')	Name	
C4	How the care is being funded? (Place a cross in the relevant boxes) ⇆	Local authority	☐
		PCT	☐
		Local authority and PCT jointly	☐
		Self-funded by the person, their family, etc	☐
		Funded through insurance, etc	☐

C5 WHY THIS REQUEST IS BEING MADE		
	Place a cross in ONE of the boxes below (A–G) ➢	
Boxes A–D relate to people who ARE NOT currently subject to a standard authorisation		
A	**PERSON WHO IS ALREADY ACCOMMODATED HERE BUT IS NOT YET BEING DEPRIVED OF LIBERTY** The person is already accommodated in this hospital or care home. We are not depriving them of their liberty. However, during the next 28 calendar days, it is likely that we will need to do so and that they will meet all of the qualifying requirements for a standard authorisation.	☐
B	**PERSON WHO IS ALREADY ACCOMMODATED HERE AND BEING DEPRIVED OF THEIR LIBERTY** The person is already accommodated in this hospital or care home. They already appear to meet all of the qualifying requirements for a standard authorisation. An urgent authorisation has been given pending the outcome of the standard authorisation assessment process.	☐
C	**PERSON IS NOT YET ACCOMMODATED HERE BUT WILL NEED TO BE DEPRIVED OF THEIR LIBERTY HERE DURING THE NEXT 28 DAYS** The person is not yet accommodated in this hospital or care home. However, during the next 28 days it is likely that they will be admitted and that they will need to be deprived of their liberty here. It is also likely that they will meet all of the qualifying requirements for a standard authorisation.	☐
D	**COURT OF PROTECTION ORDER ABOUT TO EXPIRE** The person is already accommodated in this hospital or care home. We are already depriving them of their liberty and the Court of Protection has authorised this. However, given the date on which the court's order is expected to expire, it would be unreasonable to delay any longer requesting a standard authorisation.	☐
Boxes E–G relate to people who ARE currently subject to a standard authorisation		
E	**EXISTING AUTHORISATION ABOUT TO EXPIRE: NEW STANDARD AUTHORISATION REQUIRED** There is already a standard authorisation in force that covers the person's deprivation of liberty in this hospital or care home. It is reasonable to request a new standard authorisation to come into force immediately after the expiry of the existing authorisation.	☐
F	**CHANGE IN THE PLACE WHERE THE PERSON IS DEPRIVED OF LIBERTY** There is already a standard authorisation in force. However, it does not authorise the person's deprivation of liberty in this hospital or care home. We therefore require a new standard authorisation that authorises their deprivation of liberty here.	☐

G	**A PART 8 REVIEW HAS BEEN REQUESTED OR IS IN PROGRESS** There is already a standard authorisation in force that authorises the person's deprivation of liberty in this hospital or care home. A review of this authorisation under Part 8 of Schedule A1 to the Mental Capacity Act 2005 has either been requested or is being carried out. Any new standard authorisation that is now given will be in force after the existing authorisation comes to an end. ☐

C6 ANY OTHER RELEVANT INFORMATION

Please Use Continuation Sheet

Signed (on behalf of the managing authority)	Signature	
	Print name	
	Position	
Dated	Date	

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Appendix IIIb: *Form 5 - Age Assessment*

CASE NUMBER

Mental Capacity Act 2005

DEPRIVATION OF LIBERTY FORM No. 5

AGE ASSESSMENT

An age assessment is required for a standard authorisation. However, there is no need to complete this form if the best interests assessor states that the person is aged 18 or over on the best interests assessment form.

Note that an age assessment is not required if the supervisory body has a written copy of an earlier age assessment, and there is no reason to believe it is not accurate. If you do re-use a previous assessment then you must complete Form 11.

PART A — WHY THIS FORM IS BEING COMPLETED

Place a cross in one of the boxes below ➢

A1	This form is being completed in relation to a request for a standard authorisation.	☐
A2	This form is being completed in relation to a review of an existing standard authorisation under Part 8 of Schedule A1 to the Mental Capacity Act 2005.	☐

PART B — BASIC INFORMATION

Name, address and profession of the assessor	Name	
	Address	
	Profession	
Full name of the person being assessed	Name	
Name of the hospital or care home in which the person is, or may become, deprived of their liberty	Name	
Name of the PCT or local authority that is the supervisory body	Name	

1

The present address of the person being assessed (Place a cross in the relevant box and, where applicable, state the address)	As stated on the request for a standard authorisation	☐
	As stated immediately below	☐
	Address	
Address of the hospital or care home in which the person is, or may become, deprived of their liberty (Place a cross in the relevant box and, where applicable, state the address)	As stated on the request for a standard authorisation	☐
	As stated immediately below	☐
	Address	

PART C — RECORD OF THE ASSESSMENT

I have assessed whether the person meets the age requirement.

In carrying out this assessment, I have taken into account any information given to me, and any submissions made, by any of the following:

(a) any relevant person's representative appointed for the person

(b) any IMCA instructed for the person in relation to their deprivation of liberty.

Enter the person's date of birth in row C1 or place a cross in box C2 or C3 ➢

C1	The person's date of birth is:	☐
C2	I have not been able to establish the person's date of birth. However, to the best of my knowledge and belief s/he will be **AGED 18 OR OVER** when the requested standard authorisation comes into force.	☐
C3	I have not been able to establish the person's date of birth. However, to the best of my knowledge and belief s/he will be **UNDER 18 YEARS OF AGE** when the requested standard authorisation comes into force.	☐

PART D — REASONS FOR OPINION

Give here the reasons for your opinion that the person is aged 18 or over, or is under 18 years of age.

Please Use Continuation Sheet

Signed

Dated

WHAT TO DO NOW

It is essential that you give a copy of this assessment to the supervisory body as soon as you have completed it. This is because the supervisory body may not give a standard authorisation unless and until it has written copies of all the assessments. If the person will be under 18 years of age when the proposed standard authorisation would come into force, then they do not meet the age qualifying requirement. As a result a standard authorisation may not be given and all other on-going assessments should stop. You should immediately notify the supervisory body, and then provide them with a copy of this assessment as soon as practicable. You must keep a written record of the assessment.

Appendix IIIc: *Form 6 - Mental Health Assessment*

CASE NUMBER

Mental Capacity Act 2005

DEPRIVATION OF LIBERTY FORM No. 6

MENTAL HEALTH ASSESSMENT

PART A — WHY THIS FORM IS BEING COMPLETED

Place a cross in ONE of the boxes below ➢

A1	This form is being completed in relation to a request for a standard authorisation.
A2	This form is being completed in relation to a review of an existing standard authorisation under Part 8 of Schedule A1 to the Mental Capacity Act 2005.

PART B — BASIC INFORMATION

Name and address of the assessor	Name	
	Address	
Full name of the person being assessed	Name	
Name of the hospital or care home in which the person is, or may become, deprived of their liberty	Name	
Name of the PCT or local authority that is the supervisory body	Name	
The present address of the person being assessed (Place a cross in the relevant box and, where applicable, state the address)	As stated on the request for standard authorisation	
	As stated immediately below	
	Address	
Address of the hospital or care home in which the person is, or may become, deprived of their liberty (Place a cross in the relevant box and, where applicable, state the address)	As stated on the request for standard authorisation	
	As stated immediately below	
	Address	

1

PART C — RECORD OF THE ASSESSMENT

I have assessed whether the person meets the mental health requirement.

In carrying out this assessment, I have taken into account any information given to me, and any submissions made, by any of the following:

(a) any relevant person's representative appointed for the person

(b) any IMCA instructed for the person in relation to their deprivation of liberty.

Place a cross in EITHER box C1 OR box C2 below ➢

C1	In my opinion, the person **IS** suffering from mental disorder within the meaning of the Mental Health Act 1983 (disregarding any exclusion for persons with learning disability).	☐
C2	In my opinion, the person **IS NOT** suffering from mental disorder within the meaning of the Mental Health Act 1983[1] (disregarding any exclusion for persons with learning disability).	☐
	If you completed box C1, also complete box C3	

C3 In my opinion, the mental disorder from which the person is suffering is (enter diagnosis or, if this is not established, describe the nature of the person's disorder, e.g. dementia, depression).

Please Use Continuation Sheet

Give here a brief clinical description of the main symptoms and signs.

Please Use Continuation Sheet

1 References in this form to provisions of the Mental Health Act 1983 include provisions of other enactments that have the same effect

2

I have considered how the person's mental health is likely to be affected by being deprived of their liberty in this hospital or care home. In my opinion, their mental health is likely to be affected in the following ways:

Briefly state here how their mental health is likely to be affected.

Please Use Continuation Sheet

Signed

Dated

WHAT TO DO NOW

It is essential that you give a copy of this assessment to the supervisory body as soon as you have completed it. This is because the supervisory body may not give a standard authorisation unless and until it has written copies of all the assessments.

If you have placed a cross in box **C2**, to indicate that the person is not suffering from mental disorder, then the person does not meet the mental health qualifying requirement. As a result, a standard authorisation may not be given and all other on-going assessments should stop. You should immediately notify the supervisory body, and then provide them with a copy of this assessment as soon as practicable. You must keep a written record of the assessment.

If the person is suffering from mental disorder, you must notify the best interests assessor of your conclusions as to how the person's mental health is likely to be affected by their being deprived of their liberty. You can do that by giving them a copy of this form.

Appendix IIId: *Form 7 - Mental Capacity Assessment*

CASE NUMBER

Mental Capacity Act 2005

DEPRIVATION OF LIBERTY FORM No. 7

MENTAL CAPACITY ASSESSMENT

PART A — WHY THIS FORM IS BEING COMPLETED

Place a cross in ONE of the boxes below ➢

A1	This form is being completed in relation to a request for a standard authorisation.
A2	This form is being completed in relation to a review of an existing standard authorisation under Part 8 of Schedule A1 to the Mental Capacity Act 2005.

PART B — BASIC INFORMATION

Name, address and profession of the assessor	Name	
	Address	
	Profession	
Full name of the person being assessed	Name	
Name of the hospital or care home in which the person is, or may become, deprived of their liberty	Name	
Name of the PCT or local authority that is the supervisory body	Name	
The present address of the person being assessed (Place a cross in the relevant box and, where applicable, state the address)	As stated on the request for a standard authorisation	
	As stated immediately below	
	Address	
Address of the hospital or care home in which the person is, or may become, deprived of their liberty (Place a cross in the relevant box and, where applicable, state the address)	As stated on the request for a standard authorisation	
	As stated immediately below	
	Address	

1

PART C — RECORD OF THE ASSESSMENT

I have assessed whether the person meets the mental capacity requirement.

In carrying out this assessment, I have taken into account any information given to me, and any submissions made, by any of the following:

(a) any relevant person's representative appointed for the person

(b) any IMCA instructed for the person in relation to their deprivation of liberty.

The managing authority proposes to accommodate the person in the hospital or care home so that they can be given the care or treatment specified in their request for this standard authorisation.

In my opinion, all practicable steps have been taken to help the person to make their own decision in relation to this question.

I have assessed capacity in accordance with the principles and requirements of the Mental Capacity Act 2005.

Place a cross in EITHER box C1 OR box C2 below ➢

C1	In my opinion the person **LACKS** capacity to make their own decision about whether they should be accommodated in this hospital or care home for the purpose of being given the proposed care and/or treatment because of an impairment of, or a disturbance in the functioning of, the mind or brain.	☐
C2	In my opinion the person **HAS** capacity to make their own decision about whether they should be accommodated in this hospital or care home for the purpose of being given the proposed care and/or treatment.	☐

WHY THE PERSON LACKS CAPACITY TO MAKE THIS DECISION FOR THEMSELVES

If you placed a cross in box C1, also place a cross in ONE OR MORE of the boxes below (C3–C6) ➢

C3	The person is unable to understand the information relevant to the decision. *(The information relevant to a decision includes information about the reasonably foreseeable consequences of deciding one way or another, or failing to make the decision.)*	☐
C4	The person is unable to retain the information relevant to the decision. *(The fact that a person is able to retain the information relevant to a decision for a short period only does not prevent them from being regarded as able to make the decision.)*	☐
C5	The person is unable to use or weigh that information as part of the process of making the decision.	☐
C6	The person is unable to communicate their decision (whether by talking, using sign language or any other means).	☐

REASONS FOR OPINION

Give your reasons for deciding that it has or has not been established that the person lacks capacity to make their own decision about whether to be accommodated in the hospital or care home for the purpose of being given the proposed care and/or treatment because of an impairment of, or a disturbance in the functioning of, the mind or brain.

Please Use Continuation Sheet

Signed

Dated

WHAT TO DO NOW

It is essential that you give a copy of this assessment to the supervisory body as soon as you have completed it. This is because the supervisory body may not give a standard authorisation unless and until it has written copies of all the assessments.

If you have placed a cross in box **C2**, to indicate that the person has capacity in relation to the relevant question, then the person does not meet the mental capacity qualifying requirement. As a result, a standard authorisation may not be given and all other on-going assessments should stop. You should immediately notify the supervisory body, and then provide them with a copy of this assessment as soon as practicable. You must keep a written record of the assessment.

Appendix IIIe: *Form 9 - Eligibility Assessment*

CASE NUMBER

Mental Capacity Act 2005

DEPRIVATION OF LIBERTY FORM No. 9

ELIGIBILITY ASSESSMENT

PART A — WHY THIS FORM IS BEING COMPLETED

Place a cross in ONE of the boxes below ➢

A1	This form is being completed in relation to a request for a standard authorisation.
A2	This form is being completed in relation to a review of an existing standard authorisation under Part 8 of Schedule A1 to the Mental Capacity Act 2005.

PART B — BASIC INFORMATION

Name, address and profession of the assessor	Name	
	Address	
	Profession	
Full name of the person being assessed	Name	
Name of the hospital or care home in which the person is, or may become, deprived of their liberty	Name	
Name of the PCT or local authority that is the supervisory body	Name	
The present address of the person being assessed (Place a cross in the relevant box and, where applicable, state the address)	As stated on the request for a standard authorisation	
	As stated immediately below	
	Address	
Address of the hospital or care home in which the person is, or may become, deprived of their liberty (Place a cross in the relevant box and, where applicable, state the address)	As stated on the request for a standard authorisation	
	As stated immediately below	
	Address	

1

PART C — STATUTORY CONSULTATION

In carrying out this assessment, I have taken into account any information given to me, or submissions made, by any of the following:

(a) any relevant person's representative appointed for the person

(b) any IMCA instructed for the person in relation to their deprivation of liberty.

C1 REQUIREMENT TO SEEK ELIGIBILITY INFORMATION FROM THE BEST INTERESTS ASSESSOR.

Place a cross in ONE of the following boxes (A, B, C) ➢

A	I also carried out the best interests assessment.	☐
B	The requested standard authorisation relates to the person's deprivation of liberty in a care home.	☐
C	The requested standard authorisation relates to the person's deprivation of liberty in a hospital. I have, to the extent that I am required to do so by the regulations[1] made under paragraph 47 of Schedule A1 to the Mental Capacity Act 2005, asked the best interests assessor for any information s/he has relevant to my making a decision about whether or not the person is ineligible to be deprived of liberty by virtue of paragraph 5 of Schedule 1A to the Mental Capacity Act 2005.	☐

Please now complete:

- **Part D of the form if the authorisation relates to a care home; OR**
- **Part E of the form if the authorisation relates to a hospital.**

PART D — CARE HOME CASES ONLY

Answer ALL of the following questions Yes or No, by placing a cross in the relevant box.
Note: if the answer to ANY of the following questions is 'Yes' then the person is NOT eligible to be deprived of their liberty under a standard authorisation. Only if the answer to ALL of the questions is 'No' is the eligibility requirement met.

Give answers to questions based on what you expect the person's circumstances to be if and when the requested standard authorisation comes into force. For example, if the person is currently detained under section 3 of the Mental Health Act 1983[2], but will not be when any standard authorisation comes into force, for these purposes they are not detained under section 3.

1 The relevant regulation is regulation 15 of the Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008, accessible via: http://www.dh.gov.uk/en/SocialCare/Deliveringadultssocialcare/MentalCapacity/MentalCapacityActDeprivationofLibertySafeguards/DH_084948

2 References in this form to provisions of the Mental Health Act 1983 include provisions of other enactments that have the same effect.

D1 PERSONS CURRENTLY LIABLE TO DETENTION UNDER THE MENTAL HEALTH ACT 1983			
A	(i) The person is liable to be detained under one of the following sections of the Mental Health Act 1983: sections 2, 3, 4, 35–38, 44, 45A, 47, 48 or 51; AND (ii) accommodating them in this care home would conflict with a requirement imposed on them in connection with their liability to detention under the Mental Health Act 1983, for example as a condition of a leave of absence or conditional discharge from hospital.	Yes	No
D2 PERSONS ON A COMMUNITY TREATMENT ORDER UNDER THE MENTAL HEALTH ACT 1983			
A	The person is on a community treatment order and accommodating them in this care home would conflict with a requirement imposed on them under their community treatment order, for example because they are being recalled to hospital or because a condition of their community treatment order is that they should reside elsewhere.	Yes	No
D3 PERSONS SUBJECT TO GUARDIANSHIP UNDER THE MENTAL HEALTH ACT 1983			
A	The person is subject to guardianship and accommodating them in this care home would conflict with a requirement imposed on them by their guardian, for example a requirement that they should reside elsewhere.	Yes	No
Please now sign and date the form. You do not need to complete Part E.			
PART E — HOSPITAL CASES ONLY **Answer ALL of the following questions Yes or No, by placing a cross in the relevant box.** Note: if the answer to ANY of the following questions is 'Yes' then the person is NOT eligible to be deprived of their liberty under a standard authorisation. Only if the answer to ALL of the questions is 'No' is the eligibility requirement met. Give answers to questions based on what you expect the person's circumstances to be if and when the requested standard authorisation comes into force. For example, if the person is currently detained under section 3 of the Mental Health Act 1983, but will not be when any standard authorisation comes into force, for these purposes they are not detained under section 3. **E1 PERSONS CURRENTLY LIABLE TO DETENTION UNDER THE MENTAL HEALTH ACT 1983**			
A	The person **is detained** in a hospital under one of the following sections of the Mental Health Act 1983: 2, 3, 4, 35–38, 44, 45A, 47, 48 or 51.	Yes	No

E2 PERSONS WHO ARE SUBJECT TO ONE OF THE ABOVE SECTIONS BUT WHO ARE NOT CURRENTLY DETAINED (FOR EXAMPLE BECAUSE THEY HAVE LEAVE TO BE ABSENT FROM THE HOSPITAL WHERE THEY ARE LIABLE TO DETENTION OR BECAUSE THEY HAVE BEEN CONDITIONALLY DISCHARGED)			
A	The purpose for which the requested standard authorisation would be given consists wholly or partly of medical treatment for mental disorder in a hospital.	Yes	No
B	Accommodating the person in this hospital under the requested standard authorisation would conflict with a requirement imposed on them in connection with their liability to detention under the Mental Health Act 1983, for example as a condition of a leave of absence or conditional discharge from hospital.	Yes	No
E3 PERSONS ON A COMMUNITY TREATMENT ORDER UNDER THE MENTAL HEALTH ACT 1983			
A	The person is on a community treatment order and the purpose for which the requested standard authorisation would be given consists wholly or partly of medical treatment for mental disorder in a hospital.	Yes	No
B	The person is on a community treatment order and accommodating them in the hospital under the requested standard authorisation would conflict with a requirement imposed on them under the community treatment order.	Yes	No
E4 PERSONS SUBJECT TO GUARDIANSHIP UNDER THE MENTAL HEALTH ACT 1983			
A	The person is on guardianship and accommodating them in the hospital under the requested standard authorisation would conflict with a requirement imposed on them by their guardian.	Yes	No
B	The person is subject to guardianship and objects to being accommodated in the hospital for the purpose of being given some or all of the medical treatment proposed for their mental disorder. No donee of a lasting power of attorney or deputy appointed by the Court of Protection has made a valid decision to consent to the matters to which they object.	Yes	No
E5 PERSONS WHO COULD BE DETAINED UNDER THE MENTAL HEALTH ACT 1983			
A	• The person objects to being in this hospital in order to be given medical treatment for their mental disorder or to being given some or all of the mental health treatment; **AND** • no donee or deputy 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 section 2 or 3 of the Mental Health Act 1983.	Yes	No

Please now sign and date the form.
Signed
Dated

WHAT TO DO NOW

It is essential that you give a copy of this assessment to the supervisory body as soon as you have completed it. This is because the supervisory body may not give a standard authorisation unless and until it has written copies of all the assessments.

If the person does not meet the eligibility qualifying requirement, a standard authorisation may not be given and all other on-going assessments should stop. You should immediately notify the supervisory body, and then provide them with a copy of this assessment as soon as practicable. You must keep a written record of the assessment.

Appendix IIIf: *Form 10 - Best Interests Assessment*

CASE NUMBER

Mental Capacity Act 2005

DEPRIVATION OF LIBERTY FORM No. 10

BEST INTERESTS ASSESSMENT

PART A — WHY THIS FORM IS BEING COMPLETED

Place a cross in ONE of the boxes below ➢

A1	This form is being completed in relation to a request for a standard authorisation. (If you place a cross in this box you must also take the person being assessed through the steps necessary to appoint a representative and complete Form 24.)	☐
A2	This form is being completed in relation to a review of an existing standard authorisation under Part 8 of Schedule A1 to the Mental Capacity Act 2005. **Note:** Where the supervisory body decides that the best interests requirement should be reviewed solely because details of the conditions attached to the authorisation need to be changed, and the review request does not include evidence that there is a significant change in the person's overall circumstances, there is not need for a full reassessment of best interests. This form does not need to be completed in such a case, and the supervisory body can simply vary the conditions attached to the authorisation in such ways, if any, as it considers appropriate. In making any decision whether a change is significant, regard must be had to the nature of the change and the period that the change is likely to last for.	☐

PART B — BASIC INFORMATION

Name, address and profession of the assessor	Name		
	Address		
	Profession		
Full name of the person being assessed	Name		
Their date of birth (or estimated age if unknown)	DOB		
	Est. age		Years
Name of the hospital or care home in which the person is, or may become, deprived of their liberty	Name		
Name of the PCT or local authority that is the supervisory body	Name		

1

The present address of the person being assessed (Place a cross in the relevant box and, where applicable, state the address)	As stated on the request for a standard authorisation	☐
	As stated immediately below	☐
	Address	
Address of the hospital or care home in which the person is, or may become, deprived of their liberty (Place a cross in the relevant box and, where applicable, state the address)	As stated on the request for a standard authorisation	☐
	As stated immediately below	☐
	Address	

PART C — PERSONS CONSULTED AND MATTERS TAKEN INTO ACCOUNT

I have assessed whether the person meets the best interests requirement.

C1 PERSONS WHO HAVE BEEN CONSULTED

Note: before embarking on the full best interests assessment consultation process, the best interests assessor may first wish to check that there is *prima facie* evidence that a deprivation of liberty may be occuring, or is likely to occur, since, if it is apparent that there is no deprivation of liberty, the full best interests consultation process will be unnecessary.

Place a cross in the boxes below to confirm the statements in A, B or C ➢

A	I have spoken to the person to whom this assessment relates, in accordance with section 4(6) of the Mental Capacity Act 2005.	☐
B	I have consulted the managing authority of the hospital or care home and taken their views into account.	☐
C	In carrying out this assessment, I have also consulted the following interested persons:	

Note: before completing the rest of Part C, please read the notes at the end of the form, and in particular the definition of 'interested persons'.

	Name	Address
1		
2		
3		
4		
5		

If more than five interested persons were consulted, please give the names and addresses of any other individuals in Part G of this form.

D	I have consulted the following additional individuals who were named by the person being assessed as people to be consulted in relation to the matters now under consideration, and have taken their views into account:

	Name	Address
1		
2		

If more than two people in this category were consulted, please give the names and addresses of any other individuals in Part G of this form.

3

E	I have consulted the following additional individuals, who are engaged in caring for the person being assessed or are interested in their welfare, and have taken their views into account:	
	Name	Address
1		
2		

If more than two people in this category were consulted, please give the names and addresses of any other individuals in Part G of this form.

C2 MATTERS THAT I HAVE CONSIDERED AND TAKEN INTO ACCOUNT

I have considered what I believe to be all of the relevant circumstances and, in particular, the matters referred to in section 4 of the Mental Capacity Act 2005. ☐

I have taken into account the conclusions of the mental health assessor as to how the person's mental health is likely to be affected by their being deprived of liberty. ☐

I have taken into account any assessment of the person's needs in connection with accommodating the person in the hospital or care home. ☐

I have taken into account any care plan that sets out how the person's needs are to be met while the person is accommodated in the hospital or care home. ☐

In carrying out this assessment, I have taken into account any information given to me, or submissions made, by any of the following:

(a) any relevant person's representative appointed for the person

(b) any IMCA instructed for the person in relation to their deprivation of liberty.

Note: if this form is being used to record a Part 8 review assessment, and the best interests requirement is being reviewed solely because details of the conditions attached to the standard authorisation need to be changed in a situation in which there is a significant change in the person's overall circumstances, now proceed directly to Part F4 of this form.

PART D — WHETHER PERSON MEETS THE BEST INTERESTS REQUIREMENT

Note: if the answer to ANY of the questions D1 to D4 is No then the person is NOT eligible to be deprived of their liberty under the Mental Capacity Act 2005. Only if the answer to ALL of the questions below is Yes is the best interests requirement met.

In my opinion:

Place ONE cross in each row (no need to complete questions D2 to D4 if the answer to question D1 is No) ➢

D1	The person is, or is to be, kept in the hospital or care home for the purpose of being given care or treatment in circumstances that amount to depriving them of their liberty.	Yes ☐	No ☐
D2	This is in the person's best interests.	Yes ☐	No ☐
D3	This is necessary in order to prevent harm to the person.	Yes ☐	No ☐
D4	This is a proportionate response given the likelihood that the person will otherwise suffer harm and the seriousness of that harm.	Yes ☐	No ☐

Reasons for opinion

D5	The reasons for my opinion concerning whether or not the proposed arrangements for the person's care and/or treatment amount to depriving them of their liberty in the hospital or care home are:

Please Use Continuation Sheet

5

D6	If the proposed arrangements amount to depriving the person of their liberty, the reasons for my opinion that they are, or are not, in the person's best interests are:

Note: you should consider the provisions of section 4 of the Mental Capacity Act 2005, the additional factors referred to in paragraph 4.61 of the deprivation of liberty safeguards Code of Practice and all other relevant circumstances. Remember that the purpose of the person's deprivation of liberty must be to give them care or treatment. You must consider whether any care or treatment the person needs can be provided effectively in a way that is less restrictive of their rights and freedom of action.

Please Use Continuation Sheet

D7	If the proposed arrangements amount to depriving the person of their liberty, the reasons for my opinion that they are, or are not, necessary in order to prevent harm to the person are:

Note: include particulars of the harm that will be avoided by depriving the person of their liberty.

Please Use Continuation Sheet

6

D8	If the proposed arrangements amount to depriving the person of their liberty, the reasons for my opinion that they are, or are not, a proportionate response to the likelihood of the person otherwise suffering harm and the seriousness of that harm are:

Note: include why the risk of harm, and the seriousness of the harm, justifies deprivation of liberty.

Please Use Continuation Sheet

Please go on to:

- **Part E of the form if the best interests requirement is not met; OR**
- **Part F of the form if the best interests requirement is met.**

PART E — BEST INTERESTS REQUIREMENT IS NOT MET

Part E must be completed if you decided that the best interests requirement is not met.

Place a cross in EITHER box E1 or E2 below ➢

E1	For the reasons given above, it appears to me that the person **IS, OR IS LIKELY TO BE,** deprived of their liberty. In my view, the deprivation of their liberty under the Mental Capacity Act 2005 is not appropriate. Consequently, unless the deprivation of liberty is authorised under other statute, the person is, or is likely to be, subject to an unauthorised deprivation of liberty.	☐
E2	For the reasons given above, it appears to me that the person **IS NOT, OR IS NOT LIKELY TO BE,** deprived of their liberty. Consequently, the person is not, or is not likely to be, subject to an unauthorised deprivation of liberty.	☐

If you have put a cross in box E1, please offer any suggestions that you have that may be beneficial to the commissioners and/or providers of services in deciding on their future action. This might, for example, include a recommendation about an alternative approach to care or treatment that would avoid deprivation of liberty:

Please Use Continuation Sheet

PART F — BEST INTERESTS REQUIREMENT IS MET

If you are recording a Part 8 review assessment simply record the maximum authorisation period already granted and ignore Box F2

F1 MAXIMUM AUTHORISATION PERIOD

State period in the box below. This must not exceed one year ➢

In my opinion, the maximum period it is appropriate for the person to be deprived of liberty under this standard authorisation is:

F2 DATE WHEN THE STANDARD AUTHORISATION SHOULD COME INTO FORCE

I recommend that the standard authorisation should come into force:

Place a cross in box A or enter the date in row B ➢

A	As soon as possible	☐
B	On (date):	

8

F3 RECOMMENDATIONS AS TO CONDITIONS

Complete F3 if you are completing this form in connection with a request for a standard authorisation.

Complete F4 INSTEAD if you are completing this form to record a Part 8 review assessment.

Do NOT complete both F3 and F4.

See the notes at the end of this form for guidance on imposing conditions.

Place a cross in box A or box B ➢

A	I have no recommendations to make as to the conditions to which any standard authorisation should or should not be subject (proceed to Part G of this form).	☐
B	I recommend that the conditions specified immediately below should be attached to any standard authorisation that is given.	☐

Any standard authorisation given should be subject to the following conditions:

(If more than six conditions are recommended, please add any additional conditions in Part G.)

1	
2	
3	
4	
5	
6	

9

Should any recommended conditions not be imposed: **If you have made recommendations about conditions, place a cross in one of the boxes below ➢**		
A	I would like to be consulted again, since this may affect some of the other conclusions that I have reached in my assessment.	☐
B	I do not need to be consulted again, since I do not think that the other conclusions reached in this assessment will be affected.	☐
F4 RECOMMENDATIONS AS TO VARYING ANY CONDITIONS **Only complete F4 if you are using this form to record a Part 8 review assessment. In all other cases, do not complete F4.** **Place a cross in EITHER box A OR box B ➢**		
A	I am of the opinion that the existing conditions to which the standard authorisation is subject are appropriate and should not be varied.	☐
B	I recommend that any existing conditions to which the standard authorisation is subject should be varied in the way shown immediately below.	☐
The conditions to which the standard authorisation is subject should be varied so that the person is now subject to the following conditions and to no others: **(If there are more than six conditions, please add any additional conditions in Part G of this form.)**		
1		
2		
3		
4		
5		

6	

PART G — ANY OTHER RELEVANT INFORMATION

Please use the space below to record any other relevant information, including any additional conditions that should or should not be imposed and any other interested persons consulted by you.

Please Use Continuation Sheet

PART H — THE AGE ASSESSMENT

Place a cross in ONE of the four boxes below ➢

H1	The person's date of birth is given on the first page of this form and this form also constitutes the age assessment that is required.	☐
H2	I have not been able to ascertain the person's exact date of birth. However, I am satisfied that they are aged 18 or over, and this form also constitutes the age assessment that is required.	☐
H3	It is not clear whether or not the person is aged 18 or over. In my opinion, a more detailed age assessment is required and Form 5 should be completed.	☐
H4	In my opinion, an age assessment is not required. The current request is for a replacement standard authorisation and there is no reason to believe that the age assessment previously done is not accurate.	☐

Signed
Dated

WHAT TO DO NOW

It is essential that you give a copy of this assessment to the supervisory body as soon as you have completed it. This is because the supervisory body may not give a standard authorisation unless and until it has written copies of all the assessments.

If the person does not meet the best interests qualifying requirement, a standard authorisation may not be given and all other on-going assessments should stop. You should immediately notify the supervisory body, and then provide them with a copy of this assessment as soon as practicable. You must keep a written record of the assessment.

Unauthorised deprivation of liberty

See below concerning the steps that must now be taken.

NOTES

Providing the eligibility assessor with relevant information

The eligibility assessor, if they are not also the best interests assessor, must ask the best interests assessor to provide them with any relevant eligibility information that the best interests assessor may have, and the best interests assessor must comply with the request. Relevant information might, for example, include:

(a) whether the person is subject to guardianship under the Mental Health Act 1983[1] or meets the statutory criteria for being detained under section 2 or 3 of that Act; and, if so

(b) whether they object to being accommodated in hospital in order to be given the treatment that it is proposed to give them there for their mental disorder; and, if they do

(c) whether any donee of a lasting power of attorney or deputy appointed by the Court of Protection has consented to each matter to which they themselves object.

Definition of 'interested persons'

Any of the following is an interested person:

(a) the relevant person's spouse or civil partner

(b) where the relevant person and another person of the opposite sex are not married to each other but are living together as husband and wife: the other person

(c) where the relevant person and another person of the same sex are not civil partners of each other but are living together as if they were civil partners: the other person

(d) the relevant person's children and step-children

(e) the relevant person's parents and step-parents

(f) the relevant person's brothers and sisters, half-brothers and half-sisters, and stepbrothers and stepsisters

(g) the relevant person's grandparents

1 References in this form to provisions of the Mental Health Act 1983 include provisions of other enactments that have the same effect

(h) a deputy appointed for the relevant person by the court

(i) a donee of a lasting power of attorney granted by the relevant person.

One person is another's partner if the two of them (whether of different sexes or the same sex) live as partners in an enduring family relationship.

Recommending that conditions are or are not imposed

According to the law, the best interests assessor may recommend that conditions should be attached to a standard authorisation, but should not specify conditions that do not directly relate to the issue of deprivation of liberty. Conditions could, for example, deal with contact issues, issues relevant to the person's culture or other major issues related to the deprivation of liberty, without which deprivation of liberty would cease to be in the person's best interests. Conditions may also be recommended to work towards avoiding deprivation of liberty in future.

Unauthorised deprivation of liberty

The supervisory body and managing authority must address the situation urgently where there is an unauthorised deprivation of liberty. The possibility of legal proceedings may arise.

Paragraph 5.24 of the deprivation of liberty safeguards Code of Practice states as follows:

> 'Where the best interests assessor comes to the conclusion that the best interests requirement is not met, but it appears to the assessor that the person being assessed is already being deprived of their liberty, the assessor must inform the supervisory body and explain in their report why they have reached that conclusion. The supervisory body must then inform the managing authority to review the relevant person's care plan immediately so that unauthorised deprivation of liberty does not continue. Any necessary changes must be made urgently to stop what would be an unlawful deprivation of liberty. The steps taken to stop the deprivation of liberty should be recorded in the care plan. Where possible, family, friends and carers should be involved in deciding how to prevent the unauthorised deprivation of liberty from continuing. If the supervisory body has any doubts about whether the matter is being satisfactorily resolved within an appropriately urgent timescale it should alert the inspection body.'