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HPFT

Detention under the Mental Health Act or Deprivation of Liberty under a Deprivation of Liberty Safeguards authorisation (DoLS)

This policy will guide staff when making decisions about whether it is appropriate to use the MHA or DoLS when it is necessary to deprive a patient of their liberty

HPFT Policy

Version	3
Executive Lead	Executive Director Quality and Safety
Lead Author	Mental Health Act Quality Manager
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Target Audience	HPFT staff who are involved with issues where it may be necessary to deprive a patient of their liberty using the provisions of the MHA or the Mental Capacity Act Deprivation of Liberty Safeguards (DoLS)

Document on a Page

Title of document	Detention under the Mental Health Act or Deprivation of Liberty under a Deprivation of Liberty Safeguards authorisation (DoLS)		
Document Type	Policy		
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Version	**Issue Date**	**Review Date**	**Lead Author**
3	11/10/2021	11/10/2024	Mental Health Act Quality Manager
Staff need to know about this policy because (complete in 50 words)	This document provides information and processes for HPFT staff to use to help determine which legislation is appropriate and in which circumstances. HPFT staff should be able to identify the correct legal framework that governs a patient's appropriate deprivation of liberty and be able to determine whether the MHA or the MCA DoLS should be used to authorise such a deprivation of liberty		
Staff are encouraged to read the whole policy but I (the Author) have chosen three key messages from the document to share:	(Insert three key messages from the document to share) • All staff authorising the informal admission of patients are responsible for ensuring that their capacity and consent to admission has been assessed, and that the proposed care and treatment upon admission is not likely to constitute an unlawful deprivation of liberty. The appropriate Capacity Assessment and Best Interests Decision forms should be completed via the EPR as a means of recording steps taken to assess capacity and make decisions in the person's best interests. • The choice of legal regime should never be based on a general preference for one regime or the other, or because one regime is more familiar to the decision-maker than the other. Decision-makers should not proceed on the basis that one regime is generally less restrictive than the other. Both regimes are based on the need to impose as few restrictions on the liberty and autonomy of patients as possible. • A person who lacks capacity to consent to being accommodated in a hospital for care and/or treatment for mental disorder and who is likely to be deprived of their liberty should never be informally admitted to hospital (whether they are content to be admitted or not).		
Summary of significant changes from previous version are:	Full review of policy- no significant changes		

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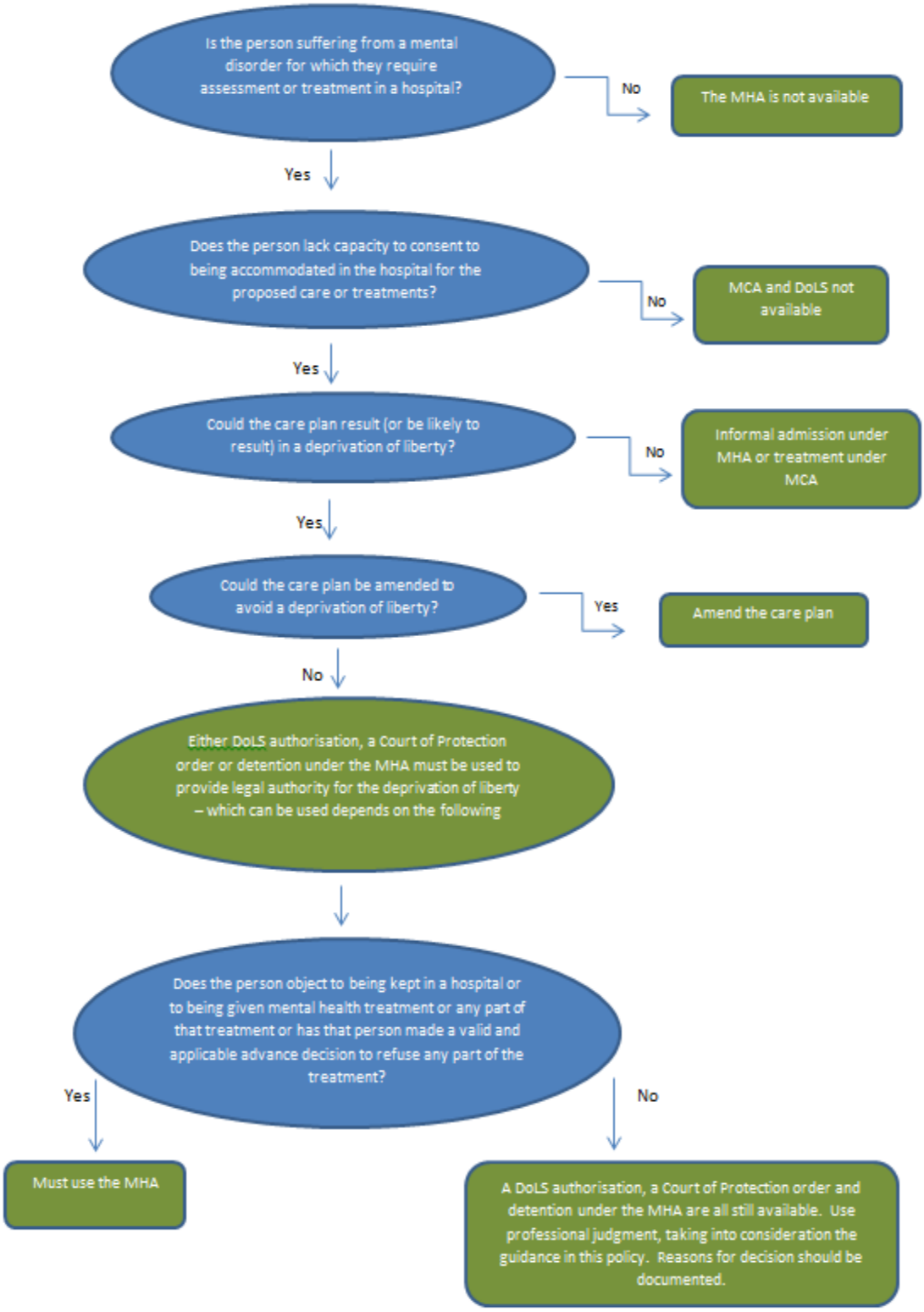
PART 1 – Preliminary Issues:

1. Options Grid summarising the availability of the Act and of DOLS

	Individual **objects** to the proposed accommodation in a hospital for care and/or treatment; or to any of the treatment they will receive there for mental disorder.	Individual **does not object** to the proposed accommodation in a hospital for care and/or treatment; or to any of the treatment they will receive there for mental disorder
Individual has the capacity to consent to being accommodated in a hospital for care and/or treatment	Only the MHA is available	The MHA is available, informal admission might also be appropriate. Neither DOLS authorisation nor Court of Protection order available
Individual lacks the capacity to consent to being accommodated in a hospital for care and/or treatment	Only the MHA is available	The MHA is available. DOLS authorisation is available, or potentially a Court of Protection order

2. Flow Chart

Key decision-making steps when determining whether the Mental Health Act and/or the MCA including the DoLS will be available to be used.



Part 2 – What needs to be done and who by

3. Summary

This document provides information and processes for staff to use to help determine which legislation is appropriate and in which circumstances. This should be read in conjunction with the HPFT MCA Deprivation of Liberty Safeguards policy and HPFT MHA policies.

4. Purpose

HPFT staff should be able to identify the correct legal framework that governs a patient's appropriate deprivation of liberty and be able to determine whether the MHA or the MCA DoLS should be used to authorise such a deprivation of liberty. The Code of Practice 2015 highlights that it is essential to have a policy on this issue.

5. Definitions

- **MHA – Mental Health Act 1983 as amended by MHA**
- **MCA** – Mental Capacity Act 2005
- **DoLS** – Deprivation of Liberty Safeguards
- **Deprivation of liberty safeguards (DoLS)** – the framework of safeguards under the Mental Capacity Act 2005 (MCA), as amended by the Mental Health Act 2007, for people who need to be deprived of their liberty in their best interests
- **DoLS authorisation** – an authorisation under Schedule A1 to the MCA given by a 'supervisory body' (a local authority) which authorises a deprivation of liberty in a care home or hospital after completion of the statutory assessment process, which includes an assessment that the deprivation of liberty is in the best interests of the person
- **Court of Protection order** – a welfare order made by the Court of Protection that authorises a deprivation of liberty for an individual who lacks the capacity to decide whether or not to be accommodated in the relevant location, in their best interests.

6. Duties and Responsibilities

- **All healthcare professionals** have a duty to implement the requirements of this document within their area of responsibility and professional code of conduct and should seek clinical or legal advice through their normal channels. They must work with regard to the MHA, MCA and DoLS Codes of Practice.
- **All staff authorising the informal admission of patients** are responsible for ensuring that their capacity and consent to admission has been assessed, and that the proposed care and treatment upon admission is not likely to constitute an unlawful deprivation of liberty. The appropriate Capacity Assessment and Best Interests Decision forms should be completed via the EPR as a means of recording steps taken to assess capacity and make decisions in the person's best interests.
- **Decision makers under the Mental Health Act** are responsible for considering the availability of an alternative regime under MCA/DoLS when considering whether detention under the MHA is necessary; and to ensure that where more than one statutory regime is available and appropriate, they employ the least restrictive regime that achieves the proposed assessment or treatment in the particular circumstances of that patient's case, balanced against any potential benefits of the other regime.

- Lead Clinicians, Service Line Leads, Directorate Manager (MH Legislation) and Heads of Nursing have a role to play in resolving any disputes or disagreements in relation to which regime is to be followed.

- **Chief Executive** – Overall accountability for compliance with the Human Rights Act 1998, Equality Act 2010
- **Executive Director of Quality & Safety** – Executive leadership for MHA and MCA.
- **Directorate Manager (Mental Health Legislation)** – Responsibility for Legal issues in relation to MHA and MCA DoLS.

7. Who the legislation applies to:

Age and applicability of the MCA and DoLS:

- the MCA, in general, applies to individuals aged 16 years and over who **lack capacity for a particular decision**
- however, a DoLS authorisation can only be made in respect of an individual aged 18 or over.
- A Court of Protection order can be made in respect of individuals aged 16 or over, and
- a person must be 18 to make an advance decision to refuse treatment or create a lasting power of attorney (LPA) under the MCA.

Age and applicability of MHA

- The MHA applies to all people of all ages
- The MHA can apply to people **with capacity** to consent to admission and to those **without capacity** to consent to admission

8. What is a Deprivation of Liberty?

The Supreme Court case of P v Cheshire West and P and Q v Surrey County Council has confirmed the test to determine if there is a deprivation of liberty.

Where there is no valid consent to living arrangements, the acid test of a deprivation of liberty is that the person is:

1. Not free to leave; and
2. Under continuous supervision and control; and
3. Lacks capacity to consent to these arrangements

The test is not concerned with how benevolent the situation is nor**:**

1. Whether or not the person is objecting.
2. The “relative normality” of the placement; and
3. The reason or purpose behind the placement.

Any deprivation of liberty must therefore be authorised by a legal procedure such as the MHA or MCA DoLS. It is important that the correct legal process is used to avoid any unlawful deprivation of a person’s liberty.

9. Detention under the MHA or deprivation of liberty under DoLS

9.1 If an individual:

a. is suffering from a mental disorder (within the meaning of the MHA)
b. needs to be assessed and/or treated in a hospital setting for that disorder or for physical conditions related to that disorder (and meets the criteria for an application for admission under sections 2 or 3 of the Act)
c. has a care treatment package that may or will amount to a deprivation of liberty
d. lacks capacity to consent to being accommodated in the relevant hospital for the purpose of treatment, and
e. **does not object** to being admitted to hospital, or to some or all the treatment they will receive there for mental disorder.

Then in principle either a DoLS authorisation (or potentially a Court of Protection order) or detention under the Act would be available (subject to the assessments required for a DoLS authorisation, including the eligibility assessment). This is the one situation where the option of using either the Act or DoLS exists.

9.2 The options grid (page 4 of this policy) summarises the availability of the MHA and of DoLS where a deprivation of liberty has been identified for a mental health patient who is accommodated in hospital for the purpose of treatment for a mental disorder.

9.3 Whether 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**, the reasonableness of that objection is not the issue.

9.4 In many cases the patient will be perfectly able to state their objection. In other cases the relevant person will need to consider the patient's behaviour, wishes, feelings, views, beliefs and values, both present and past, so far as they can be ascertained. In deciding whether a patient objects to being admitted to hospital, or to some or all of the treatment they will receive there for mental disorder, decision-makers should err on the side of caution and, where in doubt, take the position that a patient is objecting.

10. Important Points for consideration

10.1 A person who lacks capacity to consent to being accommodated in a hospital for care and/or treatment for mental disorder and who is likely to be deprived of their liberty should never be informally admitted to hospital (whether they are content to be admitted or not).

10.2 Decision-makers should also consider whether an individual deprived of their liberty may regain capacity or may have fluctuating capacity. Such a situation is likely to indicate use of the MHA to authorise a deprivation of liberty over the use of a DoLS authorisation or Court of Protection order.

10.3 An individual will be ineligible for a DoLS authorisation or a Court of Protection order if they fall within Schedule 1A to the MCA, which should be considered carefully.

11. Factors to consider in deciding which regime to use

11.1 For those individuals detailed in paragraph 9 above where both detention under the Act and a DoLS authorisation or a Court of Protection order are available, decision-makers should determine which regime is the more appropriate.

11.2 The following paragraphs detail factors that should feature in this decision-making process.

11.3 The choice of legal regime should never be based on a general preference for one regime or the other, or because one regime is more familiar to the decision-maker than the other. Such considerations are not legally relevant and lead to arbitrary decision-making. In addition decision-makers should not proceed on the basis that one regime is generally less restrictive than the other. Both regimes are based on the need to impose as few restrictions on the liberty and autonomy of patients as possible. In the particular circumstances of an individual case, it may be apparent that one regime is likely to prove less restrictive. If so, this should be balanced against any potential benefits associated with the other regime.

11.4 Both regimes provide appropriate procedural safeguards to ensure the rights of the person concerned are protected during their detention. Decision-makers should not therefore proceed on the basis that one regime generally provides greater safeguards than the other. However, the nature of the safeguards provided under the two regimes are different and decision-makers will wish to exercise their professional judgement in determining which safeguards are more likely to best protect the interests of the patient in the particular circumstances of each individual case.

11.5 In the relatively small number of cases where detention under the Act and a DoLS authorisation or Court of Protection order are available, the MHA Code of Practice does not seek to preferentially orientate the decision-maker in any given direction. Such a decision should always be made depending on the unique circumstances of each case. Clearly recording the reasons for the final decision made will be important. The most pressing concern should always be that if an individual lacks capacity to consent to the matter in question and is deprived of their liberty they should receive the safeguards afforded under either the Mental Health Act or through a DoLS authorisation or a Court of Protection order.

11.6 Part 9 of the DoLS Code of Practice details steps to be taken if someone thinks a person is being deprived of their liberty without authorisation. These steps include raising the matter with the responsible person at the managing authority (the provider) and if necessary with the supervisory body (the local authority).

12. Complex Cases

12.1 This policy does not seek to provide definitive answers in complex cases. Every individual case is unique with a complex mix of factors that need to be considered. A patient's eligibility for detention under the Act or for a deprivation of liberty under a DoLS authorisation or a Court of Protection order should always be considered.

12.2 In most cases, only one of the regimes will be available. However, in some cases, both will be available and must be considered. Decision-makers should exercise their

professional judgement, taking legal advice where necessary, within the framework of the relevant legislation and guidance.

12.3 In the rare cases where neither the Act nor a DoLS authorisation nor a Court of Protection order is appropriate, then to avoid an unlawful deprivation of liberty it may be necessary to make an application to the High Court to use its inherent jurisdiction to authorise the deprivation of liberty. Please seek internal legal advice through your MH Legislation Department should this situation arise.

13. Disagreements

13.1 Where disagreements arise between HPFT and a Supervisory Body in relation to whether or not a patient is eligible for DoLS regime, these must immediately be raised with the relevant Service Line Lead, Head of Nursing and the Directorate Manager (Mental Health Legislation). If the Supervisory Body deem someone ineligible for DoLS on the basis that they "could" be detained under the MHA instead, it is important that this situation is immediately addressed as this means that the patient is in fact deprived of their liberty but following their assessment they deem them ineligible for DoLS. It is then **immediately** necessary for HPFT to ensure some legal procedure is put in place to authorise this deprivation of liberty. This could mean that the provisions of the MHA under Section 5 could be considered.

13.2 All other disagreements including clinicians disagreeing on which regime to follow must be directed in the first instance to relevant lead professionals within HPFT such as Lead Clinicians and Head of Nursing. Delays must not occur if a person is in fact deemed to be deprived of their liberty and a dispute about which regime to use is ongoing.

14. Training and Awareness

Course	For	Renewal Period	Delivery Mode
Mental Health Act Mental Capacity Act/ Deprivation of Liberty Safeguards	All staff that support patients subject to the MHA or DoLS	Every 3 years	E-Learning E Learning Taught course is also available

15. Process for monitoring compliance with this document

Key process for which compliance or effectiveness is being monitored	Monitoring method (i.e. audit, report, on-going committee review, survey etc.)	Job title and department of person responsible for leading the monitoring	Frequency of the monitoring activity	Monitoring Committee responsible for receiving the monitoring report/audit results etc.	Committee responsible for ensuring that action plans are completed

The number of MHA detentions and the number of DoLS applications made will be reported against	Annual Report	Directorate Manager MH Legislation	Annually	Quality and Risk Management Committee	Mental Health Act Quality and Policy Group
Regular audits in relation to evidence of Capacity Statements, Best Interests Decisions and completion of DoLS forms	Annual Report	MHA Quality Manager	Annually	Quality and Risk Management Committee	Mental Health Act Quality and Policy Group

16. Embedding a culture of equality and respect

The Trust promotes fairness and respect in relation to the treatment, care and support of service users, carers and staff.

Respect means ensuring that the particular needs of 'protected groups' are upheld at all times and individually assessed on entry to the service. This includes the needs of people based on their age, disability, ethnicity, gender, gender reassignment status, relationship status, religion or belief, sexual orientation and in some instances, pregnancy and maternity.

Working in this way builds a culture where service users can flourish and be fully involved in their care and where staff and carers receive appropriate support. Where discrimination, inappropriate behaviour or some other barrier occurs, the Trust expects the full cooperation of staff in addressing and recording these issues through appropriate Trust processes.

Access to and provision of services must therefore take full account of needs relating to all protected groups listed above and care and support for service users, carers and staff should be planned that takes into account individual needs. Where staff need further information regarding these groups, they should speak to their manager or a member of the Trust Inclusion & Engagement team.

Where service users and carers experience barriers to accessing services, the Trust is required to take appropriate remedial action.

Service user, carer and/or	All rights must be given in a way that the patient can understand to enable a patient to appeal against their section should they wish to.

staff access needs (including disability)	The DoLS/MHA should not adversely and disproportionately impact on different racial or ethnic groups, gender, gender identity, disability, sexual orientation, religion/belief or age. Staff must be aware of their responsibilities and of the need to ensure that the safeguards are implemented fairly and equitably. Interpreters must be made available where necessary and must be suitably qualified and experienced. Information should be made available in other languages and alternative formats for disabled people where relevant. Decisions relating to the appointment of an Independent Mental Capacity Advocate (IMCA) or representative should take into account the cultural, national, racial or ethnic background of the relevant person.
Involvement	Patients should be made aware that they are deprived of their liberty and the reason for this. Rights must be explained and details of IMHA/IMCA should be available
Relationships & Sexual Orientation	The statutory requirements of the MHA do not discriminate against any individual, the guiding principles within the Code of Practice covers all aspects of Equality and RESPECT. The Mental Capacity Act Deprivation of Liberty Safeguards do not discriminate against any individual on the basis of this.
Culture & Ethnicity	The statutory requirements of the MHA/MCA do not discriminate against any individual, the guiding principles within the respective Code of Practice covers all aspects of Equality and RESPECT.
Spirituality	The statutory requirements of the MHA/MCA do not discriminate against any individual, the guiding principles within the respective Code of Practice covers all aspects of Equality and RESPECT.
Age	The statutory requirements of the MHA do not discriminate against any individual, the guiding principles within the Code of Practice covers all aspects of Equality and RESPECT. Only those aged over 18 can fall under the DoLS.
Gender & Gender Reassignment	The statutory requirements of the MHA/MCA do not discriminate against any individual, the guiding principles within the respective Code of Practice covers all aspects of Equality and RESPECT.
Advancing equality of opportunity	The statutory requirements of the MHA/MCA do not discriminate against any individual, the guiding principles within the respective Code of Practice covers all aspects of Equality and RESPECT.

Part 3 – Document Control & Standards Information

17. Version Control

Version	Date of Issue	Author	Status	Comment
V1	17th April 2015	Directorate Manager Mental Health Legislation	Superseded	New policy requirement within MHA Code of Practice 2015

V2	9th August 2018	Mental Health Act Quality Manager	Superseded	Policy review
V3	11th October 2021	Mental Health Act Quality Manager	Current	Policy review

18. Relevant Standards

a) Mental Health Act 1983 (as amended by MHA 2007)
b) Mental Health Act Code of Practice 2015
c) Mental Capacity Act 2005
d) Deprivation of Liberty Safeguards Code of Practice
e) Mental Capacity Act Code of Practice
f) **Equality and RESPECT:** The Trust operates a policy of fairness and RESPECT in relation to the treatment and care of service users and carers; and support for staff.

19.Associated Documents

HPFT Policy on MHA Managers Standards
HPFT Policy on Section 131/132/133 Rights.

20.Supporting References

Mental Health Act 1983
Mental Health Act 2007
Mental Capacity Act 2005
Mental Health Act Code of Practice 2015
Mental Health Act Manual 22nd Edition (Richard Jones
Mental Capacity Act
Mental Capacity Act 2005: Code of Practice
Deprivation of Liberty Safeguards: Code of Practice
Hertfordshire Mental Capacity Act Policy
HPFT Deprivation of Liberty Safeguards Policy
Care Standards Act 2000
Care Act 2014
P V Cheshire West and Chester Council 2014

21.Consultation

In the case of the Procedural Document Management System, the following have been consulted so far.

Directorate Manager MH Legislation	MH Legislation Department
MHA Quality and Policy Group	AMHP Lead

Appendices

Appendix 1 - **Guiding Principles – MHA Code of Practice, Chapter 1**

It is essential that all those undertaking functions under the Act understand the five sets of overarching principles which should always be considered when making decisions in relation to care, support or treatment provided under the Act.

The MHA Code of Practice stresses that the principles should be considered when making decisions under the Act. Although all are of equal importance the weight given to each principle in reaching a particular decision will depend on context and the nature of the decision being made.

The five overarching principles are:

- ***Least restrictive option and maximising independence***
  Where it is possible to treat a patient safely and lawfully without detaining them under the Act, the patient should not be detained. Wherever possible a patient's independence should be encouraged and supported with a focus on promoting recovery wherever possible.

- ***Empowerment and involvement***
  Patients should be fully involved in decisions about care, support and treatment. The views of families, carers and others, if appropriate, should be fully considered when taking decisions. Where decisions are taken which are contradictory to views expressed, professionals should explain the reasons for this.

- ***Respect and dignity***
  Patients, their families and carers should be treated with respect and dignity and listened to by professionals.

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- ***Purpose and effectiveness***
  Decisions about care and treatment should be appropriate to the patient, with clear therapeutic aims, promote recovery and should be performed to current national guidelines and/or current, available best practice guidelines.

- ***Efficiency and equity***
  Providers, commissioners and other relevant organisations should work together to ensure that the quality of commissioning and provision of mental healthcare services are of high quality and are given equal priority to physical health and social care services. All relevant services should work together to facilitate timely, safe and supportive discharge from detention.

Terminology	How it is to be understood	Exceptions
Must	Reflects legal obligations which it is essential to follow	No exceptions
Should	For those to whom this is statutory guidance see paragraphs II – V For those to whom it is not statutory guidance VI – VII	See paragraphs II – VII. Any exceptions should be documented and recorded including the reason for this. Patients, their families and carers, regulators, commissioners and other professionals may ask to see this
May/could/can	Reflects guidance to be followed wherever possible	Good practice but exceptions permissible

Appendix 2 - Deciding whether the Act and/or MCA will be available to be used (Explanation of Flow Chart on page 5 of this policy.)

The first question in the flowchart is to ask whether the individual in question is suffering from a mental disorder for which they require assessment or treatment in a hospital. If the answer is ‘no’, then detention under the Mental Health Act is not an available option.
If the answer is ‘yes’ then the decision-maker should consider a second question. The second question is: Does the individual in question lack the mental capacity to consent to being accommodated in the hospital for the purpose of being given the proposed care or treatment? If the answer is ‘no’ then the Mental Capacity Act and the deprivation of liberty safeguards are not an available option.

However, if the answer is ‘yes’ (in other words the individual in question is suffering from a mental disorder for which they require assessment and treatment in hospital AND they lack the capacity to consent to consent to being accommodated in the hospital for the proposed care or treatment) then the next question to be asked is: Could the care plan result, or be likely to result, in a deprivation of liberty?

If the answer is ‘no’, then the individual could be admitted to the hospital on an informal basis (i.e. not detained under the Mental Health Act) or treated under the provisions of the Mental Capacity Act (without the need to use the deprivation of liberty safeguards).

If the answer is ‘yes’ (there is, or is likely to be, a deprivation of liberty) then the next question is whether the care and or treatment plan could be amended to reduce any restraints or restrictions in place – thereby preventing a deprivation of liberty from arising. If the answer is ‘yes’, the care and treatment plan should be amended so that there is no deprivation of liberty.

If the care plan cannot be amended – so that there is (or is likely to be) an unavoidable deprivation of liberty, then the individual in question must either be detained under the Mental Health Act, a DoLS authorisation or Court of Protection order. The individual cannot be admitted on an informal basis.

In determining whether the MHA or the DoLS is the most appropriate way of authorising the deprivation of liberty the decision-maker should consider the question: does the individual object to being kept in the hospital or to being given mental health treatment or any part of that treatment, or has the individual made a valid and applicable advance decision to refuse any part of the treatment? If the answer to this question is ‘yes’ then use of the Mental Health Act is indicated – use of the DoLS would be inappropriate.

However, if the answer is ‘no’ (in other words, the individual is not objecting) then both detention under the Act and a DoLS authorisation or Court of Protection order are available. Decision-makers must decide under which regime the individual will be detained; the individual cannot be detained under both regimes. The choice of which regime to use should be made in the best interests of the individual – not because of the personal preference of the decision-maker.

Our Values

Welcoming Kind Positive Respectful Professional