NHS
North East Lincolnshire
Clinical Commissioning Group

NORTH EAST LINCOLNSHIRE COUNCIL
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Memorandum of Understanding (MoU)

Deprivation of Liberty in Hospital: Agreed Principles

Contents

Deprivation of liberty ("DOL") in hospital: agreed principles

Introduction

1. This document has been agreed by the following partner organisations as accurately reflecting the law in September 2018:

    a. NHS North East Lincolnshire Clinical Commissioning Group;
    b. Focus;
    c. Navigo.

2. The principles set out in this document reflect shared commissioner and provider understanding of the interface between the Mental Capacity Act 2005 ("MCA") and Mental Health Act 1983 ("MHA"). They are set out in order to support legal compliance, foster consistency of practice and reduce disagreement. The intended outcome is to ensure that service users receive support in the least restrictive way and that unavoidable deprivation of liberty is lawfully authorised in accordance with the appropriate legal regime. Practitioners must plan proactively to avoid gaps or lapses in authorisation.

3. This document addresses the law in relation to the deprivation of liberty of adult service users (aged 18 or over) in hospital for the purposes of care and/or treatment, referred to as 'P'. It does not address the position with regard to children and young people (aged under 18).

4. Practitioners are expected to follow these principles in practice. Disagreements should be escalated in accordance with the procedure described at paragraph 26 below.

Definitions

Term	Definition	Source
Mental disorder	Any disorder or disability of the mind, subject to exclusions relating to learning disability and dependence on alcohol or drugs: https://www.legislation.gov.uk/ukpga/1983/20/section/1 (but note that the learning disability exclusion does not apply when considering whether P qualifies for a DOLS authorisation – Schedule A1 MCA)	MHA s1
Medical treatment for mental disorder	Medical treatment the purpose of which is to alleviate, or prevent a worsening of, the mental disorder or one or more of its symptoms/manifestations; this may include nursing, psychological intervention, specialist mental health habilitation, rehabilitation and care. Physical treatment can fall within this definition where it is intended to alleviate the symptoms or underlying cause of a mental disorder, or is otherwise part of/ancillary to, treatment for mental disorder https://www.legislation.gov.uk/ukpga/1983/20/section/145	MHA s145
Mental capacity	P lacks mental capacity in relation to a matter if, at the material time, he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain: https://www.legislation.gov.uk/ukpga/2005/9/section/2	MCA s2/3

General points

5. All DOL in hospital must be properly authorised.

6. Occasionally it may be necessary to obtain a court order authorising DOL in hospital (usually from the Court of Protection, occasionally the High Court). However this will be the exception to the norm and the principles below must be followed in the first instance.

7. In a care/treatment setting, objective DOL is identified by applying the "acid test" set down by the Supreme Court in *Cheshire West*.

8. There will be no DOL in hospital in the exceptional cases identified by the Court of Appeal in the case of *Ferreira*. These cases concern patients in acute hospitals (usually but not exclusively on ICU) who are receiving immediately necessary life-saving treatment. However these cases are expected to be a small minority.

9. Where a DOL occurs in hospital, the usual routes for authorisation are:

    - Detention under an appropriate section of the Mental Health Act 1983 ("MHA");
    - Authorisation of deprivation of liberty under the Deprivation of Liberty Safeguards ("DOLS"). NB when restricting or restraining P, the MCA provides a defence to liability where P is unable to consent (and such restriction/ restraint is necessary and proportionate – see s5/6), but this defence does not extend to depriving P of liberty, without further authorisation.

10. There must be no gaps in authorisation during a continuing period of DOL. Either the MHA must be used, or a DOLS authorisation must be in place to cover all relevant periods.

11. Assessments of mental capacity are of supreme importance and must be undertaken with care, applying the test set out in the MCA and the guidance in the MCA Code of Practice. The question will be:

    Does P have capacity to consent to being in hospital for the purpose of receiving care and/or treatment?

12. An urgent authorisation under the DOLS will only be lawful in exceptional circumstances where the need for the deprivation of liberty is so urgent that it is in P's best interests for it to begin before a standard authorisation has been issued.

13. All relevant assessments and decisions must be clearly recorded, setting out reasons.

14. Professionals must take a fact sensitive approach, having regard to all relevant circumstances in a particular case.

Decision makers

15. A decision as to how to authorise DOL in hospital may need to be made by any of the following:

    a. A DOLS Eligibility Assessor: when assessing whether an application for a DOLS standard authorisation should be granted;
    b. An AMHP: when considering whether an application under the MHA ought to be made;

c. Hospital Managers: when considering whether continued use of the MHA is appropriate;
d. A Responsible Clinician (RC): when considering whether P ought to be discharged from MHA detention;
e. The First Tier Tribunal: when considering whether P ought to be discharged from MHA detention.

MHA or MCA/DOLS?

16. If P has capacity to take decisions as to whether they should remain in hospital to receive care and/or treatment, the DOLS cannot be used. If P, having capacity, is to be deprived of their liberty in hospital, the MHA must be used, otherwise the detention will be unlawful.

17. Likewise, where P has fluctuating capacity, the MHA should be used to authorise any period of deprivation of liberty in hospital.

18. Where P lacks capacity to take decisions as to whether they should remain in hospital to receive care and treatment, in the majority of cases there will be no choice between use of the MHA or use of DOLS as only one option for authorisation will be available – see paragraphs 19-23 below.

19. Where P lacks capacity, DOLS will not be available where P is ineligible for a DOLS authorisation, applying Schedule 1A MCA. Amongst other cases, this includes where it is proposed that P should be detained in hospital for medical treatment for mental disorder and in the judgement of the DOLS eligibility assessor:

    a. an application in respect of P could be made under section 2 or 3 of the MHA, and
    b. P could be detained in hospital under section 2 or 3 of the MHA, if an application were made, and
    c. P is objecting to receiving some or all of the proposed medical treatment for their mental disorder, or to being in hospital to receive that treatment.

20. In some cases P (who lacks capacity) will have a need for treatment for both mental and physical health. It will be necessary to determine whether P's proposed detention will be primarily for mental health or for physical health purposes. A "but for" test should be applied. The decision maker should look at:

    a. the treatment P should have for his physical disorders unconnected to his mental disorders (i.e. his package of physical treatment), and
    b. the treatment P should have for his mental disorders (including physical disorders connected to, or likely to directly affect, his mental disorder).

    The question will be:

    If it were not for the package of physical treatment, would P need to be detained in hospital for medical treatment for mental disorder?

    If yes, P's detention will be primarily for mental health and so detention under the MHA should be considered. If an application could be made under section 2 or 3 of the MHA and P is objecting, P will be ineligible for DOLS and the MHA must be used.

    If no, P's detention will be primarily for physical health and detention under the MHA will not be appropriate. Only the DOLS will be available.

21. Whether P is objecting must be considered in the round, taking into account all the circumstances, so far as they are reasonably ascertainable. Regard should be had to P's behaviour, wishes, feelings, views, beliefs and values, both present and past, so far as they can be ascertained. In deciding whether a patient is objecting, decision-makers should err on the side of caution and, where in doubt, take the position that P is objecting. Examples of objection could include verbal objection by P, P trying to leave, verbal or physical aggression towards staff or refusal of medication. If medication is being administered covertly, this will almost certainly indicate that P is objecting (otherwise covert administration could not be justified).

22. "Medical treatment" and "mental disorder" are widely defined for these purposes. Consequently P will not only be ineligible under paragraph 19 above where it is proposed that they receive treatment for psychiatric illness in a mental health unit. P may also be ineligible in other hospital settings when receiving treatment for other conditions.

23. Where P is ineligible for DOLS for the reasons set out in paragraphs 19-22 above, the DOLS cannot be used and the MHA must be used if P is to be deprived of their liberty in hospital.

24. In a minority of cases where P lacks capacity, P may be both eligible for DOLS and potentially detainable under the MHA. In these circumstances Chapter 13 of the MHA Code of Practice must be followed to determine which regime should be used.

Discharge from MHA detention onto DOLS in hospital

25. When considering discharge from MHA detention of someone already detained under the MHA, if:

    a. P lacks capacity and
    b. P is fit for discharge but is going to remain in hospital for a period of time, deprived of their liberty, whilst discharge to the community is planned, and
    c. P is not ineligible for the DOLS (because they are not objecting), and so use of the DOLS is available, and
    d. it is the view of the RC (applying Chapter 13 of the MHA Code) that use of the DOLS would be preferable and the least restrictive option for P in the interim pending discharge from hospital,

    P must not be discharged from MHA detention until a DOLS standard authorisation has been granted. If P is discharged from MHA detention before the standard authorisation is granted, any ongoing period of DOL before the standard authorisation is granted will be unlawful. A DOLS urgent authorisation cannot be used lawfully in these circumstances because the situation is not urgent.

Escalation

26. Disputes regarding choice of regime should be resolved peer to peer in the first instance, with support from their respective line managers where necessary. Where resolution fails at this level, disputes will be managed as follows:
    a. those arising within Navigo will be referred to Navigo's Medical Director
    b. those arising within focus will be referred to the Head of Safeguarding
    c. where the Medical Director and Head of Safeguarding are unable to resolve a dispute between colleagues within their respective organisations, reference will be made to the CCG's Mental Capacity Act Strategic Lead.

Case Studies to support application of MoU

William

William is a 78 year old former labourer. He's known to suffer from schizoaffective disorder which can manifest in significant changes in behaviour. These changes can be cyclical. He has recently been reviewed by MH services as there has been concern that he is potentially hallucinating again. On review he is deemed to lack capacity to consent to admission to hospital for treatment, but it is decided admission is necessary. He is admitted to an acute secondary MH unit on a Friday and an urgent DOLS authorisation is issued on the following Monday. William remains there under the DOLS.

1. What is the primary purpose of William's admission to hospital?
    a. Is it for treatment of his mental disorder?
    b. Or for treatment of some other form of ill health?

2. If the former, could William potentially be detained under the MHA?

3. Is William objecting to some or all of the proposed medical treatment for his mental disorder, or to being in hospital to receive that treatment?
    a. If yes, where does that leave us?
    b. If no, where does that leave us?

4. What authorisation is there for his conveyance to hospital on Friday?
    a. How could this be addressed?

5. What authorisation is there for his admission between Friday and Monday?
    a. How could this be addressed?

William appears to physically deteriorate and is subsequently admitted to the local acute unit for investigation for shortness of breath. He is diagnosed with COPD and discharged back to MH services

6. What form of authorisation could be used for the admission to the acute unit?

Proposed answer

We suggest that the MHA should be used for William.

The primary purpose of the admission is for medical treatment for his mental disorder. He lacks capacity and therefore cannot consent to informal admission. It is not clear where William is or whether he is objecting to admission but note that the MCA does not confer any powers of entry and may not be sufficient to authorise the conveyance. If he meets the MHA detention criteria and is objecting he will be ineligible for the DOLS. Once detained under the MHA he can go to the acute hospital under section 17 leave: the acute hospital will need to consider whether any additional form of authorisation may be needed to cover the care and treatment he receives there.

Mina

Mina is an 81 year old lady who is admitted to the MH unit under section 2 MHA. She is discharged from section 2 and regraded to informal before the end of the 28 day maximum section 2 period. She then remains in the MH unit for some weeks before being discharged to a care home provider. Whilst on the ward PRN Lorazepam is administered along with antipsychotics. Mina is not always the instigator of the request for PRN medication.

Records shows Mina lacks capacity to consent to her treatment and accommodation. On occasions Mina has pushed other patients aside and needs 2 (and sometimes 3) members of staff to ensure her personal hygiene needs are met.

1. How could Mina's discharge from section 2 be justified?

2. Where does her discharge from section leave her in legal terms? What authority is there for her continued admission to hospital?

3. Is Mina no longer deprived of her liberty when her section 2 is discharged? Or is she still deprived of her liberty in hospital?
    a. Explain your answer.

4. What is the legal authority for the treatment she receives in hospital?

<u>Proposed answer</u>

It is not clear why Mina has been discharged from her section 2. It appears that she is still deprived of her liberty in hospital after the discharge of her section 2. It appears she lacks capacity to consent to her admission. If so, she is unlawfully detained.

Mina is in hospital (MH unit) for medical treatment for an unspecified mental disorder (treated with antipsychotics). The use of Lorazepam, her behaviour towards other patients and the high staffing ratio strongly suggest she is objecting to being in hospital or to at least some of the treatment for her mental disorder. If so she will be ineligible for the DOLS.
The legal authority for her treatment (without consent) is unclear.

We suggest that Mina should have remained under the MHA (section 2, then section 3 after no more than 28 days) until her discharge from hospital to the care home provider. There must be a clear and lawful justification for keeping her in hospital and providing her with treatment in the interim. Otherwise, she must be allowed to leave.

Janice
Janice is a 66 year old lady, admitted under section 2 MHA on 7th Feb from an acute (general hospital) provider to an acute MH unit.
Janice is assessed as lacking capacity to consent to her care, treatment and accommodation in hospital.

The section 2 ends after 28 days. On 13th March the MH hospital issues an urgent DOLS authorisation and applies for a standard authorisation. Janice is discharged on 28th March back to her home where she is cared for by her husband.

1. Is it right simply to allow Janice's section 2 to expire?
    a. How else could this have been approached?

2. Where does the expiry of Janice's section 2 leave her in legal terms?
    a. Is she still deprived of her liberty in hospital? Explain your reasoning.
    b. What authority is there for her continued admission to hospital?

3. In what circumstances can an urgent authorisation legitimately be used?
    a. Is this a legitimate use of an urgent authorisation?
    b. If not, where does this leave Janice in legal terms from 13 March?

<u>Proposed answer</u>
There appears to be no proper authorisation for the continued deprivation of Janice's liberty once her section 2 has expired.

It is not clear why Janice's section 2 has been allowed to expire. Before expiry, consideration must be given by the RC to the authority for her continued admission to hospital. She is not able to give her own consent. We presume she will continue to be deprived of her liberty in hospital, given the later attempt to use the DOLS to authorise this. In that case her continuing deprivation of liberty this will need to be authorised either under the MHA (by using section 3) or under the MCA (DOLS authorisation). There must be no gap in authorisation, otherwise the deprivation of her liberty will be unlawful during the period of the gap.

Janice's eligibility for the DOLS will need to be considered.

If she would be ineligible for the DOLS, the continuing deprivation of her liberty can only be authorised using the MHA (section 2 followed by section 3).

If she would be eligible for DOLS, she should remain under the MHA (using section 3 if necessary) until a standard authorisation is granted by the supervisory body, otherwise there will be a period of unlawful deprivation of liberty in the interim.

An urgent authorisation cannot lawfully be used in these circumstances because the circumstances are foreseeable and not urgent.

Melanie

Melanie is a 70 year old lady living in a care home. She has dementia. She is admitted to an out of area provider because of her aggressive behaviour on 1st October and detained under section 2 MHA. She is transferred to the in-area acute MH provider on 3rd October. On 26th Oct the section 2 is discharged and Melanie is re-graded as informal. It is recorded that she "could be managed on DOLS".

An urgent DOLS authorisation is put in place and a standard authorisation requested on the 26th October.

Melanie is discharged to a care home provider on 27th November. In the period of time following the discharge of her section 2, Melanie continues to receive antipsychotic medication. Notes detail that her behaviour is deteriorating as well as assaults on a service user and member of staff. Notes continue to say Melanie remains hostile.

1. Could it have been right to discharge Melanie from section 2 MHA on 26 October?
    a. Please explain your answer.

2. Can Melanie legitimately be considered an informal inpatient from 26 October?
    a. Please explain your answer.

3. Would Melanie be eligible for a DOLS authorisation from 26 October onwards?
    a. Please explain your answer.

4. In what circumstances can an urgent authorisation legitimately be used? Is this a legitimate use of an urgent authorisation?
    a. Please explain your answer.

5. In light of your answers above, where does this leave Melanie in legal terms from 26 October?

6. What could have been done instead in order to ensure that all periods of deprivation of liberty are properly authorised?

<u>Proposed answer</u>

We suggest that Melanie should not have simply been discharged from her section 2 and instead an application should have been made for her continued detention under section 3 MHA.

It is not clear why Melanie was discharged from the MHA on 26 October. Given that a DOLS application has been made the same day, she has presumably been assessed as lacking capacity in relevant contexts and is still considered to be deprived of her liberty upon discharge of the section 2. She continues to receive medical treatment for her mental disorder, without her consent. In that case it is highly likely she will meet the criteria for continued detention under section 2 followed by section 3 MHA.

Her behaviour strongly suggests she is objecting to being in hospital or to at least some of the treatment for her mental disorder. If so she will be ineligible for the DOLS and the MHA must continue to be used to authorise her ongoing detention in hospital.

It is contradictory to deem Melanie informal but also issue an urgent authorisation.

The urgent authorisation will not be lawful because: 1) the circumstances are foreseeable and not urgent; 2) Melanie will almost certainly be ineligible for the DOLS.

Melanie's deprivation of liberty from 26 October appears to be unlawful. She should have remained under the MHA until her discharge from hospital.

Alan part 1
Alan, aged 73, has been admitted to Greentrees Ward for treatment for his dementia. He is assessed as lacking capacity to consent to the care regime, which is assessed as amounting to continuous supervision and control. Alan would not be allowed to leave hospital. He is described as wholly compliant with his care regime, well settled and appears to be content. He has never tried to leave nor indicated he wants to. His family are happy with his care plan.

Because of the concern that Alan is deprived of his liberty he has been made subject to s3 MHA. It is now argued he should be discharged from section.

1. Do you agree that Alan is deprived of his liberty in hospital?
    a. Please explain your answer.

2. What are the options for authorisation of Alan's deprivation of liberty in hospital?
    a. Please set out each, explaining why they are available.

3. Is Alan eligible for an authorisation under the DOLS?
    a. Please explain your answer.

Proposed answer
It appears that Alan is deprived of his liberty in hospital because he lacks mental capacity in relevant contexts, his situation satisfies the "acid test" set down in *Cheshire West*, and the arrangements for his residence and care are attributable to the state.

The MHA has already been used to authorise his admission and this may well be justifiable and lawful. We know that he is receiving treatment for a mental disorder in hospital. We would need to know more about the facts of his case to be sure that the section 3 MHA criteria have been applied correctly but they may well have been.

If Alan truly is wholly compliant and well settled, he may be eligible for a DOLS authorisation as an alternative to remaining under the MHA. Under Schedule 1A MCA (Case E) he would be ineligible if he met the criteria for detention under ether section 2 or section 3 MHA and was objecting to receiving some or all of the proposed medical treatment for his mental disorder, or to being in hospital to receive that treatment. If he is truly wholly compliant (which will need to be assessed carefully), it will follow that he is not objecting, in which case a DOLS authorisation may be available if he also meets the other qualifying requirements.
The decision maker will need to consider which regime (MHA or MCA/DOLS) would be most appropriate for Alan, having regard to the guidance in Chapter 13 of the MHA Code of Practice.

If Alan would be eligible for a DOLS authorisation, and this is the preferred option for him, he should remain under the MHA until a standard authorisation is granted. This will ensure there are no gaps in authorisation.

Alan part 2
You now learn that Alan is being covertly medicated.

4. Does this change any of your answers to question 1-3 above?
    a. Please explain your reasoning.

Proposed answer

The use of covert medication may be justifiable but it will almost certainly indicate that Alan is objecting to some or all of the treatment for his mental disorder. If Alan is not objecting it is difficult to see how covert medication could be justified.

If Alan is objecting to some or all of the treatment for his mental disorder, he will not be eligible for the DOLS and if he will continue to be deprived of his liberty in hospital, this will need to be authorised under the MHA (i.e. he should not be discharged from section 3).

Charlie

Charlie is admitted to Greentrees Ward under section 2 MHA for treatment of his dementia. He is assessed as lacking capacity with regard to his admission and treatment. He is subject to continuous supervision and control on the ward and he would not be allowed to leave if he wished to. Charlie is described as 'wholly compliant' on the ward. However nursing staff also say that he becomes upset when he has visitors and tries to leave with them (but is prevented from doing so).

At a Hospital Manager's hearing his solicitor argues he should be discharged from section and remain in hospital informally.

1. Do you agree that Charlie is deprived of his liberty in hospital?
    a. Please explain your answer.

2. What are the options for authorisation of Charlie's deprivation of liberty in hospital?
    a. Please set out each, explaining why they are available.

3. Is Charlie eligible for an authorisation under the DOLS?
    a. Please explain your answer.

4. Is the solicitor right that Charlie should be discharged from the MHA and remain in hospital informally?

Proposed answer

It appears that Charlie is deprived of his liberty in hospital because he lacks mental capacity in relevant contexts, his situation satisfies the "acid test" set down in *Cheshire West*, and the arrangements for his residence and care are attributable to the state.

The MHA has already been used to authorise his admission and this may well be justifiable and lawful. We know that he is receiving treatment for a mental disorder in hospital. We would need to know more about the facts of his case to be sure that the section 2 MHA criteria have been applied correctly but they may well have been.

Because Charlie lacks capacity and is deprived of his liberty in hospital, he cannot be discharged from the MHA and remain as an informal patient. The deprivation of his liberty must be authorised under either the MHA or the MCA/DOLS, otherwise he will be unlawfully detained. He cannot consent to remaining in hospital. It is clear that he will not be allowed to leave as things stand.

The fact that Charlie becomes upset and tries to leave hospital with his visitors strongly indicates that he is objecting to receiving some or all of the proposed medical treatment for his mental disorder, or to being in hospital to receive that treatment (as per Schedule 1A MCA, Case E). If so, and assuming he still meets the criteria for detention under section 2 MHA, he will be ineligible for an authorisation under the DOLS and so this will not be an option.

In that case the only option, if Charlie is to remain deprived of his liberty in hospital, is for him to remain under section 2 MHA.