



Mental Capacity Act Deprivation of Liberty Safeguards

Frequently Asked Questions

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Mental Capacity Act 2005 deprivation of liberty safeguards

FREQUENTLY ASKED QUESTIONS

BACKGROUND

What is the purpose of the deprivation of liberty safeguards?

The deprivation of liberty safeguards address the October 2004 European Convention on Human Rights judgment in *HL v the United Kingdom* (the *Bournewood* judgment), which requires that people may only be deprived of their liberty through a process set out in law, with safeguards to prevent arbitrary detention and speedy access to a Court to review the detention. The safeguards cover England and Wales.

The safeguards provide protection for a very vulnerable group of people who are cared for in hospitals, or in care homes registered under the Care Standards Act 2000 (hereafter referred to as care homes), in circumstances that deprive them of their liberty, and who are unable to consent (but who are not detained under the Mental Health Act 1983). The policy objective is to ensure that people are only deprived of their liberty when there is no other way to care for them or provide treatment to them safely.

What is the legislative basis for the safeguards?

The legislative provisions relating to the deprivation of liberty safeguards are in the Mental Capacity Act 2005. They were introduced into that Act by the Mental Health Act 2007. The safeguards are appropriate to the Mental Capacity Act 2005 because they relate to people who lack capacity to agree to arrangements made for their care and treatment. Incorporation of the safeguards in the Mental Capacity Act 2005 enables the principles of that Act to apply, for example requiring support for the person to decide about their care themselves where possible, and all actions to be in the best interests of the person concerned and in the least restrictive manner possible.

Does the deprivation of liberty safeguards legislation include any regulation-making powers?

There are regulation-making powers covering a number of topics:-

- the information to be included in requests for standard authorisations of deprivation of liberty,
- the eligibility and selection of people to undertake assessments for the purpose of the deprivation of liberty authorisation process,
- the eligibility and appointment of people to be relevant person's representatives, i.e. to become an independent representative of a person in respect of whom deprivation of liberty is authorised,
- the need to ensure that any dispute about which local authority should be the supervisory body for the purpose of the deprivation of liberty safeguards process should

not delay any decision making about whether the deprivation of liberty should be authorised.

- the prescribing of bodies to monitor, and report on, the operation of the deprivation of liberty safeguards,
- the disclosure of information to such prescribed bodies.

Draft regulations on the last two bullet points are currently being developed, and will be consulted on later. Draft regulations on the other topics mentioned above were the subject of a consultation exercise that ended on 2 December 2007. Those draft regulations can be accessed on the Department of Health closed consultations web pages http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH_078052 . Consideration is now being given to how the draft regulations should be revised in the light of the consultation responses.

There is also a regulation-making power to enable the reduction of the maximum 12 month standard authorisation period for deprivation of liberty if monitoring of the operation of the safeguards indicates that to be necessary at a later stage. It is not proposed to use this regulation-making power at the present time.

Why is this regulation-making power not being used now – 12 months is too long for a single authorisation to last?

The current approach, which sets the time period of the authorisation on a case by case basis taking account of individual circumstances, is considered to be most appropriate for the population that the safeguards will cover. In many cases, authorisation will in any event be for less than 12 months. There are further safeguards in that care homes and hospitals are required to trigger a review if circumstances change, and the person or their representative may trigger a review at any time. The 12 month maximum is a longstop for a case where the best interests assessor considers that there is unlikely to be a change within 12 months and so authorisation should be for that long, and neither the hospital nor care home nor the person nor their representative have triggered a review. The regulation-making power has, however, been taken in case monitoring of the operation of the safeguards indicates that 12 months is being used as the norm.

What is the Bournemouth judgment?

On 5 October 2004 the European Court of Human Rights gave judgment in the case of HL v the United Kingdom (the “Bournemouth” judgment). The Court held that an autistic man (HL), who lacked the capacity to consent to or to refuse admission to hospital for treatment, was deprived of his liberty when he was admitted informally to Bournemouth Hospital. The Court further held that:-

- The manner in which HL was deprived of liberty was not in accordance with “a procedure prescribed by law”, and was therefore in breach of Article 5(1) of the European Convention on Human Rights (ECHR); and

- because HL was not able to have the lawfulness of his detention decided speedily by a court with appropriate powers, there had been a contravention of Article 5(4) of the ECHR.

Why has it taken so long to respond to the European Court judgment?

It has always been the Government's intention to address the deprivation of liberty issues raised by the Bournemouth judgment. A consultation was carried out in 2005 to seek views on the proposed policy response to the judgment. The policy was further developed in the light of the consultation outcome, and during the passage of the Mental Health Bill, now the Mental Health Act 2007, through Parliament. The process has taken a long time but the Government wanted to make sure that the right response to the judgment was arrived at. The Government believes this has been achieved through the deprivation of liberty safeguards legislation.

What was the outcome of the 2005 policy consultation process?

A report on the outcome of the policy consultation process was published on 29 June 2006. The report is available on the Department of Health website http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4136789. The report summarises the key issues raised in response to the consultation and, where appropriate, explains why the Government took a different view from that of respondents. Whilst a range of views were expressed in response to the consultation, the overall picture was one of general support for the "Protective Care" proposals outlined in the consultation document. The deprivation of liberty safeguards that have subsequently been developed remain broadly in line with those Protective Care proposals, although some amendment has been made in the light of the responses to the consultation and further thinking.

When will the safeguards come into force?

It is currently envisaged that the deprivation of liberty safeguards will come into effect from April 2009. Between now and then we will be seeking to ensure that all interested parties are made aware of the safeguards and how they should be operated. We will also be seeking to ensure that those responsible for implementing the safeguards are appropriately trained to undertake their roles. Code of Practice guidance on the safeguards is being developed for the information of all those people who will have any involvement with the deprivation of liberty safeguards. Draft Code of Practice guidance was the subject of a consultation exercise that ended on 2 December 2007. This draft guidance can be accessed on the Department of Health closed consultations web pages http://www.dh.gov.uk/en/Consultations/Closedconsultations/DH_078052. It is intended that the guidance will be finalised by mid-2008.

COVERAGE OF THE SAFEGUARDS

Who will the deprivation of liberty safeguards cover?

It is intended that the deprivation of liberty safeguards should cover people suffering from a mental disorder, who lack capacity in relation to the question of whether or not they should be resident in a hospital or care home and who are assessed as needing to be deprived of liberty, within the meaning of Article 5 of the ECHR, in their own best interests, in either hospitals or

care homes, to protect them from harm, and to ensure they receive the care and/ or treatment they need. The safeguards are not to be used solely to protect other people from harm. Nor do they apply to people who receive the necessary Article 5 safeguards by virtue of being detained under the Mental Health Act 1983.

The safeguards will largely embrace older people and people with learning disabilities. It is not anticipated that the deprivation of liberty safeguards should impact in any significantly different way on different ethnic groups, but it is expected that cultural issues will be borne in mind when the procedures are used.

How many people will come within the scope of the deprivation of liberty safeguards?

Deprivation of liberty should be avoided whenever possible, and should only be authorised in cases where it is the only way to keep the person safe. We estimate that authorisation would only be justified for between 1,000 to 5,000 cases each year.

There will be more people than this who need to be assessed because there is a question about whether they are, or should be, deprived of liberty. We anticipate that initially care homes and hospitals will be cautious and will apply for authorisation if there is any question that one might be needed. In the first year we estimate that 21,000 people will be assessed (leading to about 5250 authorisations).

As care homes and hospitals become more familiar with the meaning of deprivation of liberty, and how to avoid it, we expect the annual number of assessments to fall to about 5000 by 2015/16 (leading to about 1250 assessments).

We accept that there is uncertainty around these estimates. This is inevitable given that the distinction between restriction and deprivation of liberty has to be made on a case by case basis.

What if the person objects to being deprived of their liberty under the deprivation of liberty safeguards?

If the authorisation would be for mental health treatment in hospital and the person objects to being in hospital, or to all or part of the treatment, then the deprivation of liberty safeguards procedures cannot be used if the Mental Health Act 1983 could be used instead (except in a case where a donee of Lasting Power of Attorney or a deputy appointed by the court, operating within their powers, consents on the person's behalf to the admission or treatment to which they object). This is in order to treat the person as far as possible in an equivalent way to a person who has capacity and who objects.

It is possible that a person who lacks capacity could be deprived of their liberty in a care home when they object or appear to object. This could only happen if the best interests assessment had concluded that the deprivation of liberty was a necessary and proportionate measure in the person's best interests to protect them from harm, and to ensure they receive the care and/or treatment they need.

Do the deprivation of liberty safeguards apply to private care placements?

Under the Human Rights Act 1998, the duty to act in accordance with the ECHR applies only to public authorities. However, all states are obliged to make sure that the rights set out in the ECHR apply to all of their citizens. The deprivation of liberty safeguards therefore apply to both publicly and privately arranged placements. So deprivation of the liberty of a person who lacks the capacity to consent in any hospital or registered care home, as a result of either a public or a private arrangement, will not be lawful unless covered by an authorisation or resulting from an order of the Court of Protection on a personal welfare matter.

What about deprivation of liberty other than in hospitals or care homes?

While there may be other people suffering from a mental disorder and lacking capacity who might be deprived of their liberty outside hospitals or care homes (for example, in their own homes, in supported living arrangements other than registered care homes or in day centres), the Government consider that this should be rare. Such deprivation of liberty would only be lawful if it were a consequence of giving effect to an order of the Court of Protection on a personal welfare matter, in accordance with the provisions of the Mental Capacity Act 2005.

The Government should offer protection to everyone in hospital or care homes who lack capacity, rather than focus on those at risk of being deprived of their liberty

We are proposing to do what is necessary to provide protections that are compliant with the ECHR. It is not our intention to introduce burdens over and above this, which would divert resources from improving care and treatment for these people. The Mental Capacity Act 2005 is intended to protect and empower anybody who lacks capacity irrespective of whether or not they are in hospital or a care home.

The law should be preventing deprivation of liberty not rubber-stamping it

It is the intention of the Government that deprivation of liberty should be avoided wherever possible and we consider that introduction of the deprivation of liberty safeguards will further that aim. We issued guidance in December 2004 describing best practice that, when followed, would avoid deprivation of liberty in many cases. The draft deprivation of liberty Code of Practice guidance also emphasises that deprivation of liberty should be avoided if at all possible. The deprivation of liberty safeguards must be provided if a care home or hospital considers that deprivation of liberty cannot be avoided. The purpose of the independent best interests assessment is to establish whether the person could be safely cared for and/or treated within a less restrictive care regime, in which case deprivation of liberty will not be authorised.

Will the deprivation of liberty safeguards affect BME groups disproportionately?

We do not have evidence to suggest that BME groups are likely to be disproportionately affected by the deprivation of liberty safeguards, either by being too often or not often enough made subject to an authorisation and the safeguards that brings.

We plan to:-

- monitor the use of the deprivation of liberty safeguards by ethnic group;

- emphasise that the responsibility of the supervisory body to select suitable assessors includes consideration of the cultural background of the person concerned;
- emphasise the importance of taking account of cultural and religious factors in assessing best interests, and include this element in the competences for assessors.

Why don't the deprivation of liberty safeguards apply to 16 and 17 year olds?

If it is necessary for a person aged 16 or 17, who lacks capacity to consent to the arrangements made for their care or treatment, to be deprived of their liberty, legal safeguards are available under the Children Act 1989 or, if the relevant criteria are met, under the Mental Health Act 1983. We do not consider that it is necessary to introduce additional legal protections for 16 and 17 year olds. Providing for deprivation of liberty under the Mental Capacity Act 2005 as an additional legal route to consider is not therefore appropriate.

THE AUTHORISATION PROCESS

Who should obtain a deprivation of liberty authorisation?

The managing authority of a hospital or care home has responsibility for applying for a standard authorisation of deprivation of liberty. This need will arise when somebody lacking capacity to consent to the arrangements being made for their care or treatment is, or is going to be, deprived of their liberty, within the meaning of Article 5 of the ECHR, in the hospital or care home. This process is not required though where the person concerned is detained under the Mental Health Act 1983.

A supervisory body (the relevant PCT or local authority, or the National Assembly for Wales) is responsible for considering requests for standard authorisations, commissioning assessments and, where all the assessments agree, authorising deprivation of liberty.

Where deprivation of liberty needs to be authorised in an emergency, the managing authority may itself issue an urgent authorisation pending completion of the standard authorisation application process. An urgent authorisation may initially be for a maximum of seven days but may be extended by the supervisory body for up to a further seven days in exceptional circumstances.

Will statutory deprivation of liberty forms and policies be provided?

There is no scope for the development of statutory forms, since these would have to be provided for in the primary legislation. However, we do intend to develop standard forms for a number of the deprivation of liberty safeguards processes, and consideration is currently being given to what aspects these standard forms should cover. Further information about this will be put into the public domain as soon as possible.

We will expect the organisations involved in implementing the deprivation of liberty safeguards provisions to develop their own policies. The Code of Practice guidance is available to support this process.

Why do you allow an urgent authorisation to be in place for up to 14 days before the full assessment process has to be completed? This is too long when something as important as deprivation of liberty is at stake. The Mental Health Act 1983 emergency detention is for a maximum of 72 hours.

An urgent authorisation should last for as short a time as possible, and we expect supervisory bodies to ensure that this is the case. An urgent authorisation may only initially be given for a maximum of seven days and any extension of that timescale should only occur in exceptional circumstances.

The period for which the urgent authorisation is given needs to be sufficient to allow time for the completion of the six assessments to decide whether a standard authorisation for deprivation of liberty will be given. 21 days is allowed for the standard authorisation assessment process. Because deprivation of liberty is already occurring, this assessment period is truncated to seven days where urgent authorisations are concerned. The aim is to have the assessments completed as quickly as possible, but it is essential that they are conducted thoroughly and that the outcome is correct. It is unrealistic to expect that this can usually be achieved within 72 hours.

The best interests assessment, for example, involves seeking views of family members, friends, carers, professionals involved in the person's care and any IMCA who has been appointed, and also considering whether a less restrictive regime is possible. It will be a time-consuming process to do this assessment properly, and there may be difficulties in accessing all the people who need to be consulted. The Mental Health Act 1983 does not contain such a best interests requirement, and so it is realistic to complete assessments more quickly.

A reduction of the urgent authorisation timescale from a maximum of seven days to a maximum of three is likely to result in many more requests being made to supervisory bodies for extensions of urgent authorisations, imposing additional administrative burdens on both managing authorities and supervisory bodies and with the overall result that more people may be detained for longer than seven days.

Why have separate supervisory bodies for care homes and hospitals?

We consider that, as a matter of principle, the responsibility for authorising lawful deprivation of liberty in a hospital should lie with a PCT, as the body with responsibility for healthcare in the locality, or with the National Assembly for Wales, and similarly the responsibility regarding care homes should lie with the local authority, as the body with responsibility for social care.

PCTs and local authorities may reach decisions locally on how to administer the deprivation of liberty safeguards that involve joint working.

Aren't these provisions likely to be very burdensome for example for small care homes? What support will be available?

The only new requirement is to make written application to the supervisory body for authorisation if a resident in the care home is, or is at risk of being, deprived of liberty. The other responsibilities for care homes to keep people's care under review, to act in the person's best interests and in the least restrictive manner and to communicate with the person and their family are all aspects of current good practice.

We will be providing training, information and guidance on the deprivation of liberty safeguards, linked with other Mental Capacity Act 2005 training and guidance, to support all those involved in implementing the safeguards. We are consulting with stakeholders about what needs to be addressed in information and guidance to support implementation and the care home sector will be fully involved.

Will care homes be able to understand the safeguards and identify deprivation of liberty?

We recognise that there are challenges for the care home sector in implementing the safeguards and we are working with representative organisations for care homes on how best to support their members. In response to their views, we have included guidance on how to identify deprivation of liberty in the draft Code of Practice.

We expect care homes to become increasingly confident in understanding and applying the Mental Capacity Act 2005 and in that context they will routinely be considering whether residents have the capacity to consent to elements of their care plan. We accept that identifying whether someone who lacks capacity is being deprived of liberty raises a new responsibility that may seem daunting when it is unfamiliar. However, care home managers are already required to consider how to promote choice, independence and involvement of residents and their friends and family in decision-making and, in practice, their role is not likely to be burdensome because in the vast majority of cases it will be clear that the person is not deprived of liberty.

We accept that it is essential to provide easy to use information and guidance on the deprivation of liberty safeguards. We are working on an implementation strategy to achieve this that will start from the premise of asking NHS and social care staff, service users and families what they would find useful.

How will hospitals and care homes know when they must apply for an authorisation?

Hospitals and care homes, and authorities commissioning care, will need to ensure they have systems in place relating to the implementation of the deprivation of liberty safeguards.

When making arrangements to provide care to a person who lacks capacity to consent to those arrangements, and a restriction of the liberty of that person is involved, consideration will always need to be given to whether what is proposed amounts in practice to a deprivation of that person's liberty within the meaning of Article 5 of the ECHR. Deprivation of liberty safeguards Code of Practice guidance about factors that will need to be considered in deciding whether deprivation of liberty arises will help them to do this.

The question of whether the person is deprived of their liberty will need to be kept under review and addressed explicitly whenever a change is made to the care plan. This consideration should be recorded in the person's health and care records.

What action can relatives or friends take if they believe a person is being deprived of liberty without the managing authority having applied for an authorisation?

If anyone is concerned that a person may be deprived of their liberty without the protection of the safeguards, and has drawn this to the attention of the managing authority, asking them to apply for an authorisation but they have not done so, then that person can themselves apply to the supervisory body. The supervisory body must appoint someone who would be suitable and eligible to be a best interests assessor in the case to assess whether the person is deprived of liberty. If there is no one to consult among family and friends, an IMCA would be instructed to support and represent the person.

If the outcome of the assessment is that there is an unauthorised deprivation of liberty then the full assessment process would be completed as if an authorisation had been applied for. If the managing authority consider that the care regime should continue while the assessments are carried out, they will be required to issue an urgent authorisation and to obtain a standard authorisation within seven days.

This enables someone who is concerned that there is an unauthorised deprivation of liberty taking place, and who is not able to resolve this to their satisfaction with the managing authority, to trigger the deprivation of liberty assessment process themselves. This is in addition to the possibility of pursuing the formal complaints process or of applying to the Court of Protection to hear the case.

What happens when a deprivation of liberty authorisation comes to an end?

When an authorisation ends, the managing authority cannot lawfully continue to deprive a person of their liberty. If the managing authority considers that a person will still need to be deprived of liberty after the authorisation ends, they need to request a further standard authorisation to begin immediately after the expiry of the existing authorisation.

There is no specified time limit on how far in advance of the expiry of one authorisation the application for a renewal authorisation may be made. It will need to be far enough in advance for the renewal authorisation to be given before the existing authorisation ends. Managing authorities and supervisory bodies will want to ensure that the possible need for a renewal authorisation is considered within an appropriate timescale before an existing authorisation expires. A mechanism for flagging up the potential need for renewal no later than, say, a month before the expiry date of an existing authorisation might, for example, be advisable.

Once under way, the process for renewing a standard authorisation is basically the same as for obtaining an original authorisation, with the same assessment processes needing to take place. However, the need to instruct an IMCA will not usually arise because most people at this stage will already have a person appointed to represent their interests.

Why is there no clear definition of deprivation of liberty in either the legislation or the Code of Practice guidance?

The meaning of deprivation of liberty is essentially a question for the Courts. The ECtHR made clear that the question of whether someone has, in fact, been deprived of liberty depends on the particular circumstances of the case. Specifically, the Court said that: "*It is not disputed that*

in order to determine whether there has been a deprivation of liberty, the starting-point must be the concrete situation of the individual concerned and account must be taken of a whole range of factors arising in a particular case such as the type, duration, effects and manner of implementation of the measure in question. The distinction between a deprivation of, and restriction upon, liberty is merely one of degree or intensity and not one of nature or substance.”

It is not possible to derive a definitive definition of deprivation of liberty that could be applied universally from the case-specific ECtHR judgements. Nor is it possible to state that a particular measure would or would not constitute a deprivation of liberty in ECHR terms in every case. It is necessary to consider all the factors involved on an individual basis. The Code of Practice guidance summarises factors identified as relevant by the ECtHR in cases to date.

Hospitals and care homes, and authorities commissioning care, will need to take account of these factors in assessing whether a person in their care may be deprived of liberty. They will need to ensure they have systems in place so that, when making arrangements to provide care to a person who lacks capacity to consent to those arrangements, and a restriction of the liberty of that person is involved, consideration is always given to whether what is proposed amounts in practice to a deprivation of that person’s liberty within the meaning of Article 5 of the ECHR.

Could use of sedation constitute a deprivation of liberty?

Consideration of whether a person is deprived of their liberty needs to take account of all the relevant factors in their case, which could include medication.

Does a deprivation of liberty authorisation bestow a power to treat the person who is the subject of the authorisation?

Although the intention to give a person treatment could sometimes be a reason for applying for a deprivation of liberty authorisation, the authorisation would not, in itself, authorise the treatment. The giving of the treatment, in the person’s best interests, would be governed by the wider provisions of the Mental Capacity Act 2005.

Second opinions should be sought before people detained under deprivation of liberty safeguards receive serious medical treatment

The deprivation of liberty authorisation only concerns deprivation of liberty not any course of treatment. Medical treatment for people who lack capacity to consent is already covered by the Mental Capacity Act 2005.

The arguments for automatic second opinions for patients who lack capacity were fully aired during the passage of the Mental Capacity Act 2005. The fact that someone is subject to the deprivation of liberty safeguards does not change those arguments, which the Government rejected in favour of requiring IMCAs to be instructed to represent any person who lacks capacity in decisions about serious medical treatment and who does not have any appropriate person, other than one engaged in providing care and treatment in a professional capacity, to consult about the matter.

Obviously, if the purpose of detention is to enable treatment to take place then this would be considered as part of the best interests assessment, which would be subject to the review, and challenge via the Court of Protection safeguards. Therefore, in such a case, a person subject to a deprivation of liberty authorisation would have additional scrutiny of whether proposed treatment is in their best interests compared to other patients who lack capacity.

THE ASSESSMENT PROCESS

What assessments need to be undertaken?

A supervisory body is required to arrange for the following assessments to be undertaken in order to establish whether or not the qualifying requirements of the deprivation of liberty safeguards are met and it is appropriate to issue a standard deprivation of liberty authorisation. The assessment process must be completed within 21 days, or within the period (up to seven days, or up to 14 days if an extension has been given by the supervisory body) for which an urgent authorisation has been granted:-

- age assessment
- mental health assessment
- mental capacity assessment
- best interests assessment
- eligibility assessment
- no refusals assessment.

If any of the qualifying requirements are not met, a deprivation of liberty authorisation cannot be given.

Is 21 days a realistic timescale within which to complete the deprivation of liberty safeguards assessment process?

The decision about whether or not a person should be deprived of their liberty is an important one, and the assessment process should not be allowed to drift on inappropriately. The best interests assessment is likely to be the most time consuming but we believe that, with a properly trained pool of people to call on, it should be possible to complete that assessment, and all the other assessments, within a 21 day period.

How many assessors will be required?

A minimum of two assessors will be required. An assessor can carry out any assessment for which they are eligible but the mental health assessment and the best interests assessment may not be undertaken by the same person.

Who will be able to be an assessor?

It will be the responsibility of the supervisory body to appoint suitable assessors taking account of the individual case.

In England, it is planned that regulations, currently in draft form, will specify that assessors need to demonstrate specified competence and to have had appropriate training, and to possess relevant experience. We will develop training modules that will link to the Mental

Capacity Act 2005 training programme and a competence framework for deprivation of liberty assessors that will be consistent with competences being developed for professionals fulfilling similar roles under the Mental Health Act 1983. In relation to Wales, this will be a matter for Welsh Ministers and the regulations prepared by them.

The draft regulations also require that assessors, other than age assessors, are insured in respect of any liabilities that might arise in connection with carrying out the assessment.

How will you make sure that the assessor takes an independent view from those proposing the deprivation of liberty?

It is proposed that, for England, the best interests assessment must be carried out by a professional who is not involved in providing care or in making decisions about the person's care. This will mean that they bring a fresh objective view to whether the proposed course of action is in the person's best interests. It is not necessary for all of the assessors to be unconnected with the person's care – there may be advantages in the mental health and mental capacity assessments being carried out by a someone who knows the person.

Anyone who has, or who is related to someone who has, a personal financial interest in the care provided to the person will not be able to be an assessor. Nor will anyone who is related to the person.

In relation to Wales, this will be a matter for Welsh Ministers and the regulations prepared by them.

Surely if the assessor works for the supervisory body and the supervisory body are funding the care then they have a conflict of interests

Professionals who will be acting as best interests assessors such as social workers and occupational therapists regularly have to take decisions with financial implications. Demonstrating necessary competences, which will include the ability to make an independent judgement, will be a requirement for assessors.

Who will be able to be a mental health assessor?

In England, draft regulations specify that the mental health assessor must be a doctor who is able to exercise objective medical expertise to assess whether a person is suffering from a mental disorder. The person will have to demonstrate the necessary competences, which will include for example understanding of the Mental Capacity Act 2005. In relation to Wales, this will be a matter for the Welsh Ministers and the regulations prepared by them.

Who will be able to be a best interests assessor?

In England, draft regulations specify that this assessment must be undertaken by a person who is an Approved Mental Health Professional, or by a suitably qualified social worker, nurse, occupational therapist or chartered psychologist who a supervisory body is satisfied has undertaken appropriate training and has the necessary skills and experience to be a deprivation of liberty assessor. That training will include specific best interests assessor training.

The draft regulations say that a person may not be a best interests assessor if they are involved in the care, or making decisions about the care, of the person to be assessed. Also, where the deprivation of liberty relates to a care home, they must not be employed at the care home or, where the deprivation of liberty relates to a hospital, must not be employed to work at the hospital.

Where the managing authority and the supervisory body are the same, for example where a local authority itself provides a residential care home, the best interests assessment may not be completed by a person who is employed to work for the body concerned. In such a case, the managing authority/supervisory body will need to identify a suitable qualified person who is not in their employ to undertake the assessment.

In relation to Wales, this will be a matter for Welsh Ministers and the regulations prepared by them.

How can the best interests assessor make a judgement about whether deprivation of liberty is occurring, given that there is no definition of deprivation of liberty?

Whilst it is not possible to give a concrete definition of what constitutes deprivation of liberty for the purposes of Article 5 of the ECHR, there is Code of Practice guidance setting out the sorts of factors that the European Court of Human Rights have identified as contributing to deprivation of liberty in past cases that they have decided.

Best interests assessors will be knowledgeable well trained professionals, who will have received specific training on the completion of deprivation of liberty safeguards best interests assessments. They will be well placed to make the necessary judgment as to whether or not a combination of factors in a particular case amounts to deprivation of liberty.

How will you ensure that the assessors share information and expertise?

We agree that it is important for the assessors to communicate. The mental health assessment will include an assessment of the impact of the proposed course of action on the person's mental health. The best interests assessor will be required to take account of this when making their assessment. The eligibility assessor and best interests assessor will also be required to communicate on the question of whether the person objects to treatment, where these two assessments are not carried out by the same person.

What will happen if the assessors do not agree?

Authorisation cannot be given if any of the assessors conclude that the person does not meet the qualifying requirements for authorisation.

This may be because the best interests assessor has decided that the person is not actually likely to be deprived of liberty. Or it may be that deprivation of liberty is not in the person's best interests or not permissible for some other reason, in which case, alternative arrangements may need to be made for the care of the person, which avoid any measures which result in deprivation of liberty. Alternatively, if the reason the patient does not meet the qualifying requirements is that it is thought they should only be detained under the Mental Health Act 1983, a Mental Health Act 1983 assessment would probably be arranged with a view to making the necessary application.

What happens if there is a donee of Lasting Power of Attorney or a deputy appointed by the Court of Protection?

Where a managing authority considers that there is a need to deprive of their liberty a person who lacks capacity to consent to the arrangements made for their care and treatment, a deprivation of liberty authorisation should be applied for in the usual way. Consent to the deprivation of liberty by an attorney or deputy would not obviate the need to seek an authorisation. However, if an attorney or deputy objects to the deprivation of liberty, the no refusals requirement of the deprivation of liberty safeguards comes into play - a deprivation of liberty authorisation cannot be given if the steps that would be taken under the authorisation conflict with a valid decision of an attorney or deputy.

Why do you not require that fresh assessments must always be completed for deprivation of liberty safeguards purposes rather than allowing for assessments up to 12 months old being used.

12 months is a reasonable period for an assessment to potentially remain valid bearing in mind the other safeguards around the matter. These safeguards are that the supervisory body must have the assessment in writing, that the assessment must comply with all the requirements that a fresh assessment would have to meet and that the supervisory body must be satisfied that there is no reason why the existing assessment may no longer be accurate. Also, if it is a best interests assessment, the supervisory body must take into account any views expressed by the relevant person's representative or, if there is no representative currently in place, any IMCA who has been appointed in the interim.

The purpose in allowing a supervisory body to make use of an existing assessment is to avoid the resource implications, the potential distress to the person concerned and the delay of unnecessarily obtaining an assessment when there is already an assessment that is suitable for the purpose. An example might be where a person with dementia has been assessed as lacking the capacity to make a decision about whether or not to be admitted to a care home with there being little, if any, prospect of the person's capacity to make such a decision improving within the next 12 months.

REPRESENTATION FOR A PERSON COMING WITHIN THE SCOPE OF THE DEPRIVATION OF LIBERTY SAFEGUARDS

Will there be any independent support for a person coming within the scope of the deprivation of liberty safeguards?

Every person in respect of whom a standard deprivation of liberty authorisation is given will have a relevant person's representative appointed to support them to exercise their rights. The deprivation of liberty safeguard provisions will also specify some additional situations when the instruction of an Independent Mental Capacity Advocate (IMCA) will be required under the Mental Capacity Act 2005:-

- when an application has been made for authorisation to deprive a person of liberty who does not have family, friends or carers to support them,

- where a person or their representative need the assistance of an IMCA during the course of an authorisation, either on their own request or if a supervisory body believes that appointing an IMCA will help to ensure that the person's rights are protected,
- during gaps in the appointment of a relevant person's representative, for example if a new representative is being sought.

The role of the IMCA to support and represent the person will be equivalent to the role regarding questions of serious medical treatment or change of residence. We would expect anyone acting as an IMCA in a deprivation of liberty safeguards case to have undertaken appropriate training. IMCAs have been statutorily required under the Mental Capacity Act 2005 since April 2007 in England, and were introduced in Wales from October 2007.

In cases other than that mentioned in the second bullet above, once a relevant person's representative is appointed the role of the IMCA falls away. However, an IMCA who has been instructed in the circumstances described in the first bullet above may still apply to the Court of Protection for permission to take the relevant person's case to the Court in connection with the giving of a standard authorisation but, in doing so, the IMCA must take the views of the relevant person's representative on the matter into account.

Why is the support of IMCAs largely focused on people who do not have family, friends or carers to support them?

The role of the best interests assessor in the deprivation of liberty safeguards process is to take account of the views of family, friends and carers, who may not all be in agreement, and to form an independent judgement of whether the proposed course of action is in the person's best interests. We consider that this provides the checks and balances needed to deal with situations where family, friends and carers are willing and able to represent the person.

Families, friends and carers may well resent the imposition of an IMCA when they are willing and able to represent the person and may view it as "professionals" taking decision making away from those who know the person best. This also ensures consistency with the criteria in the rest of the Mental Capacity Act 2005 for involving an IMCA.

The deprivation of liberty safeguards do, however, provide that an IMCA can also be instructed to assist the relevant person and their representative either on their request or if a supervisory body believes that instructing an IMCA will help ensure the person's rights are protected.

Who will be able to be a relevant person's representative?

Draft regulations say that this must be a person who is over 18, who is willing to be appointed, who is not involved in the care by which the person is deprived of their liberty and who, in the opinion of the best interests assessor and the supervisory body, is able to keep in touch with the person and to represent them in matters regarding the authorisation of deprivation of liberty. In relation to Wales, this will be a matter for Welsh Ministers and the regulations prepared by them

Who chooses the relevant person's representative?

If the person has capacity to do so they may select their own representative. If the person does not have capacity to make the choice, an attorney or deputy with relevant authority may do so on their behalf. If a choice is not made as above, the best interests assessor will make a recommendation from among the people consulted during the best interests assessment. If a representative cannot be appointed from among the person's family, friends or informal carers then the supervisory body must find a person to appoint and that person may be paid.

Where will paid relevant person's representatives come from?

It will be for the supervisory body to decide how eligible relevant person's representatives will be selected in cases where best interests assessors are unable to recommend anybody. This service might, for example, be commissioned through an agency for advocacy services, ensuring that the service provides effective independent representation for the person deprived of liberty. When appointing a representative for a person who has no family members or friends taking an interest in their well-being, the supervisory body should pay particular attention to the communication and cultural needs of the relevant person.

Why are relevant person's representatives not appointed automatically like nearest relatives under the Mental Health Act 1983?

Relevant person's representatives have a different role to perform. They are purely representatives, whereas nearest relatives also retain rights to initiate and end compulsion under the Mental Health Act 1983. The use of an inflexible hierarchical list makes little sense when choosing a relevant person's representative.

In what circumstances can the relevant person's representative's appointment be ended?

Draft regulations for England say that a relevant person who has selected a family member, friend or carer as their representative can end the appointment of the representative. Similarly, an attorney or a deputy who has selected a family member, friend or carer as the representative can end the appointment of the representative. The supervisory body will be able to end the appointment of the representative if they are no longer able to fulfil the role, for example through ill health or because they are not keeping in contact with the person and therefore are not safeguarding the person's interests. The appointment will also end if the representative dies or if the period of their appointment ends.

In any such case, if deprivation of liberty is to continue, a new representative must be appointed and, if that cannot happen straightaway, an IMCA should be appointed in the interim.

In relation to Wales, this will be a matter for Welsh Ministers and the regulations prepared by them

How will the relevant person's representative be involved in the assessment process?

The relevant person's representative will not be appointed unless an authorisation is granted, that is after the assessment process has been carried out. In most cases, the person's representative will be a family member or friend, in which case they would have been consulted as part of the best interests assessment because of their relationship with the person. In the case of a person who has no family or friends able or willing to support them, an IMCA would be appointed to support and represent them during the assessment process.

Why are relatives or friends not able to exercise a power of discharge in respect of a person deprived of liberty under the deprivation of liberty safeguards?

Family and friends have the right to take steps that will result in the person being discharged if it is in the person's best interests.

A relevant person's representative will be appointed for the purpose of representing and supporting each person in respect of whom a deprivation of liberty authorisation is in force. This representative will be able to apply for a review of the authorisation by the supervisory body if they consider that the person being deprived of liberty does not meet all the qualifying requirements. The representative also has an unfettered right to apply to the Court of Protection to determine any question relating to whether or not the qualifying requirements are met.

We consider these to be robust mechanisms for determining whether or not an authorisation should remain in place, and we do not believe that it would be right for relatives and friends to have an absolute right of discharge without the matter being properly considered.

REVIEWS

What is a review and who can initiate it?

During the time when an authorisation is in force, the supervisory body may carry out a review if there is a question about whether the person meets the requirements for deprivation of liberty to be authorised, the reason the person meets the qualifying requirements or the conditions attached to the authorisation.

A review will involve reassessment of the qualifying requirements affected, for example if the request for review states that the person now has capacity to decide about their care the mental capacity assessment would be repeated. If the supervisory body is satisfied that there has been no change in circumstances affecting the issues for review described above, or if the only change is to the conditions and that change is not significant, then the review may be completed without further assessment.

The hospital or care home must monitor the person's circumstances and request a review if there is a change affecting the issues above. The person concerned or their representative may request a review at any time.

What is to stop a hospital or care home from failing to apply for a review when they should do so?

If they fail to monitor the person's circumstances and request a review when appropriate, the care home or hospital would not be complying with the requirements of the deprivation of liberty safeguards. The deprivation of liberty may therefore be unlawful and they could be subject to civil and criminal liability. Hospitals and care homes will wish to guard against this risk. If the care is publicly funded, compliance with the deprivation of liberty safeguards should be included as an element in the contractual arrangements for commissioning care.

If the person or their representative consider that there are grounds for review but the care home or hospital has not triggered a review then they can do so themselves.

What happens if a person subject to the deprivation of liberty safeguards regains capacity?

A person who regains capacity to decide about their care would no longer meet the requirements to be deprived of their liberty under a deprivation of liberty authorisation. In such circumstances, the deprivation of liberty should cease and the care home or hospital should trigger a review of the authorisation that would lead to it being terminated.

Will the person have legal representation or be able to provide independent assessments to a review?

The person or their representative may submit evidence to the supervisory body in their request for a review. There will not be legal representation or legal aid. If the person or their representative is not satisfied with the outcome of the review, they can make an application to the Court of Protection.

INTERFACE WITH THE PROVISIONS OF THE MENTAL HEALTH ACT 1983

Why weren't powers of detention under the Mental Health Act 1983 extended to all deprivation of liberty cases?

In 2005, we held a public consultation on the options for addressing the "Bournewood" gap. The options of extending use of sectioning under the Mental Health Act 1983, or adapting guardianship, were considered but were not supported by the majority of respondents. The deprivation of liberty safeguards in the Mental Capacity Act 2005 are based on the outcome of that consultation and subsequent discussions.

The Bournewood case demonstrates that we need to identify and provide safeguards for those who do not have the capacity to consent to treatment or care and who are at risk of deprivation of liberty. For some, where there is reason to believe that they would object to treatment in hospital for mental disorder, the Mental Health Act 1983 should be used. For others, we accept the overwhelming view of the respondents to the consultation that it is not appropriate to section someone simply because they lack capacity to consent, and it is this group who should be considered for the deprivation of liberty safeguards.

Why are the safeguards not the same as in the Mental Health Act 1983?

We do not consider that the safeguards under the Mental Health Act 1983 and the Mental Capacity Act 2005 need to be the same and this view was acknowledged by the ECtHR in its judgement in the Bournemouth case.

The deprivation of liberty safeguards concern protections for people who lack capacity. The Mental Capacity Act 2005 already provides safeguards concerning serious medical treatment and change of residence. The Bournemouth judgement identified that further safeguards are needed for such people who have to be deprived of their liberty in their own best interests for their own safety. The deprivation of liberty provisions provide those safeguards.

The Mental Health Act 1983 on the other hand is about detaining and treating people specifically for mental disorders that put them or others at risk, when they would otherwise not get the treatment that is necessary. No one who could be detained under the Mental Health Act 1983 will be detained in hospital for treatment under the deprivation of liberty safeguards when there is reason to believe that they would object. An exception to this is where an attorney or deputy consents on the person's behalf to the admission or treatment to which they object.

Explain the eligibility requirement/how do the Mental Capacity Act 2005 deprivation of liberty safeguards interface with the Mental Health Act 1983?

Deprivation of liberty cannot be authorised under the Mental Capacity Act 2005 in the following circumstances:

- To keep a person in hospital for mental health treatment when they would object to being in hospital or to some or all of the treatment and the Mental Health Act 1983 could be used to detain them instead (unless an attorney or deputy consents on their behalf).
- To recall to hospital someone who is subject to leave of absence, conditional discharge or a community treatment order under the Mental Health Act 1983.
- If the authorisation if granted would conflict with an obligation imposed on the person under the Mental Health Act 1983 such as a requirement on a patient subject to guardianship to live in a particular place
- If the person is detained in hospital under the Mental Health Act 1983 they cannot at the same time be deprived of liberty under the Mental Capacity Act 2005.

An authorisation cannot be granted if the person does not meet the eligibility requirement. In such a case use of the Mental Health Act 1983 could be considered as an alternative.

These arrangements are deliberately designed to avoid the two Acts conflicting with one another. By applying the rules, it will be clear to decision-makers whether the Mental Capacity Act 2005 can lawfully be used in a particular case in preference to the Mental Health Act 1983.

The eligibility arrangements also ensure that people who lack capacity to consent to hospital treatment for mental disorder, but who object to it nonetheless, will be treated as closely as possible to similar people who do have the necessary capacity and are refusing to consent.

What is to stop clinicians from using the deprivation of liberty safeguards as an easier route to detain a person than the Mental Health Act 1983?

The deprivation of liberty safeguards provisions make it clear that the safeguards cannot be used as an alternative to the Mental Health Act 1983. We accept that there are people where a judgment has to be made about which Act it is appropriate to use. This judgment concerns whether the person objects to being in hospital for mental health treatment or to all or part of the treatment. In considering whether the person objects, consideration must be given to the person's actions, feelings, beliefs, views and values from the present and past where relevant. This means that a person could be taken to object although they are not currently voicing an objection.

If an application is made to deprive a person of liberty in hospital for treatment or care for mental disorder to which the person objects an authorisation could not be granted, except in a case where an attorney or deputy consents on the person's behalf to the admission or treatment to which they object. This should be picked up by the assessment process and the application turned down if appropriate. In such cases, we would expect that a Mental Health Act 1983 assessment would usually be arranged to see if an application for detention should be made under that Act instead.

We do not accept that the deprivation of liberty safeguards are less than for Mental Health Act 1983 patients although they are different. We believe we can – and should – distinguish between patients who object to being detained for that purpose even though they lack capacity, and those who do not, just as we distinguish between patients with capacity who consent and those who do not.

THE COURT OF PROTECTION

Who can take a case about a deprivation of liberty authorisation to the Court of Protection?

Certain people have an unfettered right to be heard in the Court of Protection without needing permission. These include:

- The person who lacks capacity and is being deprived of their liberty;
- The representative appointed when the authorisation was granted;
- Any attorney appointed by the person;
- Any deputy appointed by the Court for the person.

Anyone else can apply for permission to be heard by the Court of Protection – in deciding whether to grant permission the Court will consider their relationship to the person, the reason for the application, the benefit to the person and whether the benefit could be achieved in another way.

How should cases of the type that the deprivation of liberty safeguards are designed to cover be dealt with prior to the deprivation of liberty safeguards provisions becoming law?

The new Court of Protection came into being in October 2007. The Court has the power to authorise deprivation of liberty in respect of people who lack capacity to consent to the

arrangements being made for their care or treatment and who need to be deprived of their liberty in their own best interests. Such cases should therefore be referred to the Court of Protection between now and the commencement of the deprivation of liberty safeguards of the Mental Capacity Act 2005.

Going to court is difficult and expensive, what help will be available?

Legal aid, without means testing, will be available for people subject to a standard or urgent authorisation who make application to the Court of Protection.

Who will be able to receive legal aid?

Those who are subject to an authorisation and have grounds to make application to the Court of Protection will be eligible for legal aid, which would cover court fees.

Means tested Legal Help - specialist legal advice and assistance - is available to those who need it for most Mental Capacity Act 2005 issues. This would cover the deprivation of liberty safeguards provisions.

Will legal aid be means tested?

The vast majority of civil legal aid is subject to a means test, but the Government has decided that means free legally aided representation should be available for deprivation of liberty safeguards cases in the Court of Protection.

Will there be a merits test?

There is a merits test for all categories of legal aid application, though it operates differently for certain areas. We are considering how best the merits test should work in deprivation of liberty safeguards cases. The principle will be that those who need legal aid in the Court of Protection for these cases will be able to get it.

Why will cases go to the Court of Protection rather than to Mental Health Review Tribunals?

The Mental Capacity Act 2005, in which the deprivation of liberty safeguards sit, deals with issues relating to people who lack capacity to make decisions and introduces the new Court of Protection. The Court of Protection is the arena in which disputes under the Mental Capacity Act 2005 will ultimately be resolved. It is therefore more appropriate that the Court's expertise is brought to bear on deprivation of liberty safeguards cases as they will raise issues that properly fall within their remit and area of expertise. The Court will have expertise in dealing with people who lack capacity, their friends, relatives and representatives. The Court will be recognised as having this repository of knowledge and experience and being a safe pair of hands for dealing with issues related to mental capacity.

The fact that people in receipt of the deprivation of liberty safeguards are, by definition, deprived of their liberty does not imply that Mental Health Review Tribunals are the obvious – or even the appropriate – place for disputes to be resolved.

Mental Health Review Tribunals exist to decide whether people should be discharged from detention and other forms of compulsion under the Mental Health Act 1983. Their focus is on whether people's mental disorders justify continued compulsion. Unlike the Court of Protection, they are not primarily concerned with whether people have capacity to take their own decisions, nor are they required to determine what is in the best interests of each person. They are not called on to decide whether people are in fact deprived of their liberty and they have no role in, and no experience of, matters relating to people deprived of their liberty in care homes.

The Court of Protection only has expertise in financial matters, why does the Government consider it a suitable body for deprivation of liberty safeguards cases?

Since October 2007, the Court of Protection has had a new jurisdiction of dealing with decision-making for adults who lack capacity. The new court is able to make decisions both about "property and affairs" (the term the Act uses to describe the financial decision-making jurisdiction) and also about "personal welfare" matters. It will therefore increasingly develop expertise in the health and welfare jurisdiction. Deprivation of liberty matters will relate to the personal welfare of people who lack capacity and the Court of Protection is therefore considered to be the best place for appeals to be dealt with.

The Court of Protection is a distant body that people will find threatening. This could prove a barrier. Will the Court of Protection see people in the hospital or care home?

The Court of Protection is able to call for such evidence as it requires to hear a case and applicants to the Court will be able to file evidence with their application. The Court has the power to send Court of Protection Visitors to interview applicants, parties and persons who are subject to a case before it and ask them to make a report to the Court. It would not be feasible for judges sitting in the Court of Protection to visit all people involved in capacity issues.

Will the Court of Protection be able to hear cases quickly for example if there is an appeal against an urgent authorisation?

The Court will be able to prioritise cases according to the urgency of the matter to be determined.

Can the Court of Protection overrule a valid advance decision in a deprivation of liberty safeguards case?

If an advance decision to refuse treatment is valid and applicable under section 25 of the Mental Capacity Act then it has the same effect as a refusal of treatment by a person with capacity and the decision must be followed. The Court would only be involved where there is a disagreement about the existence, validity or applicability of an advance decision. In such cases, a declaration can be sought from the Court but the Court does not have the power to overrule a valid and applicable advance decision.

Section 25(2) of the Mental Capacity Act 2005 deals with the validity of advance decisions. Section 26(4) deals with the Court's powers in relation to advance decisions. The best interests principle (section 1(5)) does not apply when an advance decision to refuse treatment is put into effect.

[Note: advance decisions to refuse treatment can be overridden in the cases of those patients subject to compulsory treatment under the Mental Health Act 1983 in the same way as a person with capacity can be compulsorily treated even if they do not consent to treatment. As people in receipt of the deprivation of liberty safeguards would not be subject to treatment under the Mental Health Act 1983, a valid and applicable advance decision to refuse treatment could not be similarly overridden and must be complied with where valid and applicable.]

Can the Court of Protection overrule a valid decision of an attorney or deputy in a deprivation of liberty safeguards case?

The Court of Protection, under section 15 of the Mental Capacity Act 2005, has the power to rule on the lawfulness or otherwise of any act done, or yet to be done, in relation to a person who lacks capacity to make their own decision about the issue in question. It also has the ability to determine whether an attorney under a Lasting Power of Attorney (LPA) or deputy is acting in a way that contravenes his authority or is not in a person's best interests.

The Court would be unlikely to overrule a valid decision of an attorney or deputy acting within the remits of the LPA or the court order. The "no refusals requirement" of the deprivation of liberty safeguards provisions makes it clear that a valid decision is one made within the scope of the deputy or attorney's authority and in accordance with Part 1 of the Act, including the best interests test. However, this is possible if the action or proposed action is not in the interests of a person who lacks capacity. In determining whether an attorney or deputy is acting or proposes to act in the best interests of a person, the Court is likely to consider the rigour of the best interests assessment undertaken by the deputy or attorney.

IMPLEMENTATION AND MONITORING

Will the operation of the deprivation of liberty safeguards be monitored?

Yes, it is our intention that the body or bodies responsible for monitoring care in hospitals, including mental health care, and care homes will, as part of that, have responsibility for monitoring the operation of the deprivation of liberty safeguards. There will be a consultation process in due course regarding the most appropriate use of the regulation-making powers relating to the monitoring of the safeguards.

CHARGING FOR CARE

There should be free aftercare services for deprivation of liberty safeguards patients - similar to the rights given to patients detained under the Mental Health Act 1983.

The two situations are not equivalent.

First, free after-care under the Mental Health Act 1983 only applies to patients who have been detained in hospital for treatment for mental disorder (and even then excludes those who have only been detained for assessment.) The deprivation of liberty safeguards will cover deprivation of liberty for many other reasons and the provision of free after care would create inequities for example with other care home residents.

Second, even when the deprivation of liberty safeguards are used to authorise the detention of incapacitated patients in hospital for treatment for mental disorder, the patients in question will

be those who do not object and who are therefore more analogous to patients with capacity who consent to such treatment. They do not get free after-care.

If a person is deprived of liberty under a deprivation of liberty authorisation their care should be free.

If a person who is receiving the deprivation of liberty safeguards is living in a care home this could only be as a result of an independent assessment that it is necessary in their best interests for their own safety. We consider that it would be inequitable to treat funding of their care differently from other people in the same care setting. This will mean that, depending on their circumstances, some people will contribute financially to the cost of their care.

Since NHS care and treatment is free at the point of delivery, the major implications of providing free care and treatment for people deprived of liberty would arise in relation to care homes. People receiving these new safeguards will largely be those with severe learning disabilities and elderly people with dementia or similar problems. Many of these groups of people will be living in a residential care setting and any financial contribution they may make is determined by local authority policy on means assessment and application of the criteria for NHS continuing care. For some individuals, the need to ensure their safety may have led to greater restrictions in their best interests, which amount to deprivation of liberty. We do not consider that this should lead to changes in the way that their care is commissioned and funded. Providing free care for those who are subject to a deprivation of liberty authorisation would create inequities between those care home residents who are deprived of liberty and those who are not.

There will be discrimination between a person deprived of their liberty in their own best interests in a hospital, who will not be charged for their care, and a person deprived of their liberty in their own best interests in a care home, who, depending on their financial situation, may be charged.

The two cases are different. A person would be in hospital because they require medical care and treatment, which is free through the NHS. A person in a care home would be receiving personal care and would be subject to the national policy on means testing whether they are deprived of liberty or not, and indeed whether they have capacity to consent or not.

WIDER CARE CONSIDERATIONS FOR OLDER PEOPLE IN CARE HOMES AND HOSPITALS

What is the Government doing to ensure that the concerns of older people in care homes are being addressed?

The Care Standards Act puts in place key building blocks of the Government's programme for modernising health and social care. It brings about the wide-scale reform of the system to protect vulnerable people, including making changes to ensure that people have access to effective complaints procedures.

Under the Act, establishments and agencies, such as care homes regulated by the Commission for Social Care Inspection (CSCI), are required to have arrangements for dealing with complaints made by, or on behalf of, those seeking or receiving any of the services provided by the establishment or agency. CSCI is responsible for ensuring that establishments

and agencies set-up and maintain comprehensive, effective and robust procedures. CSCI also has discretionary powers to investigate complaints that may inform its role as a regulator. In Wales, the corresponding body is the Care and Social Services Inspectorate Wales (CSSIW). In addition, local authorities continue to have the power to investigate complaints about social services under Section 7B of the Local Authority Social Services Act 1970.

How will this help older people?

The intention is that, in the first instance, complaints about the provision of social services in a care home should normally be made to the provider, and complaints about commissioning should be made to the authority that commissioned the person's care. Complaints about regulation should be made to CSCI or CSSIW, but complainants are also able to raise complaints with CSCI or CSSIW at any stage.

However, it should be stressed that these arrangements are not intended to be exclusive. The appropriate organisation to complain to will vary depending on the nature and circumstances of the complaint. For example, we would not expect very serious complaints on things such as abuse to be considered through the provider procedures.

What if this still doesn't resolve problems?

Anyone who is unhappy about the way their complaint was dealt by CSCI, CSSIW or the council they can proceed with their complaint through the relevant organisation's complaints procedure.

Anyone who remains unhappy about the way their complaint was dealt with can pursue their complaint through the relevant Ombudsman – the Local Government Ombudsman for a council, the Parliamentary Ombudsman for CSCI, or the Public Services Ombudsman for Wales – or they may wish to seek legal advice.

What are the regulators role in this?

All care homes in England are regulated by CSCI, and in Wales CSSIW. CSCI and CSSIW are responsible for regulating (registering and inspecting) all care homes in accordance with statutory regulations and national minimum standards to ensure consistency and improve the quality of life and level of protection for the most vulnerable people in society. CSCI must inspect care homes at least once every three years. However, CSCI has the power to inspect a care home at any time and as frequently as it thinks necessary. This enables CSCI to focus its efforts where the risks are greatest.

It is for CSCI to decide in the particular circumstances of each individual home whether the home conforms to the standards necessary to meet the assessed needs of its residents.

CSCI is an independent regulator set up by Parliament. If anyone has any concerns about the way in which CSCI carries out its regulatory functions they should take these up with CSCI. If they are unhappy with their final decision, or with the way their complaint is being handled at any stage, they can ask the Parliamentary Ombudsman to investigate.

What about complaints about NHS services?

If a person is unhappy with the treatment or service received from the NHS, they are entitled to make a complaint, have it considered, and receive a response from the NHS organisation or primary care practitioner concerned. The NHS complaints procedure applies to the NHS in England, except for NHS Foundation Trusts.

A Patient Advice and Liaison Service (PALS) has been established in every NHS Trust and primary care trust (PCT). PALS are not part of the complaints procedure itself but they might be able to resolve concerns informally or provide more information about the complaints procedure and independent complaints advocacy services.

The NHS complaints procedure covers complaints made by a person about any matter connected with the provision of NHS services by NHS organisations or primary care practitioners (GPs, dentists, opticians and pharmacists). The procedure also covers services provided overseas or by the private sector where the NHS has paid for them.

What is the process for making a complaint?

A complaint can be made by a patient or person affected or likely to be affected by the actions or decisions of a NHS organisation or primary care practitioner. A complaint can also be made by someone acting on behalf of the patient or person, with their consent.

Complaints should usually be made within six months of the event(s) concerned or within six months of becoming aware that there is something to complain about. Primary care practitioners and complaints managers in NHS organisations have discretion to waive this time limit if there are good reasons why the complaint could not be made earlier.

The first stage of the NHS complaints procedure is 'Local Resolution'. The complaint should be made in the first instance to the organisation or primary care practitioner providing the service. Local resolution aims to resolve complaints quickly and as close to the source of the complaint as possible using the most appropriate means; for example, use of conciliation.

Concerns can be raised immediately by speaking to a member of staff (e.g. doctor, nurse, dentist, GP or practice manager) or someone else, e.g. the PALS. They may be able to resolve the concerns without the need to make a more formal complaint.

However, a complaint can be pursued either orally or by writing to the primary care practitioner or the NHS organisation concerned. If the complaint is made orally a written record should be made by the complaints manager.

A response from a primary care practitioner should be received within 10 working days or from the chief executive of the NHS organisation concerned within 25 working days, though this deadline can be extended with the complainant's agreement. The complainant should be kept informed of progress if this is not going to happen.

What about Foundation Trusts?

NHS Foundation Trusts will have their own systems for the internal handling of complaints, which may differ from the 'local resolution' process described above. The NHS Foundation Trust concerned should be contacted for advice on how to make a complaint. The 'independent review' stage carried out by the Healthcare Commission does apply to NHS Foundation Trusts, which are also covered by the Health Service Ombudsman (see below for more information on this).

What if a complainant is unhappy with the handling of a complaint?

If a complainant is unhappy with the response to a complaint, including a complaint about an NHS Foundation Trust, the Healthcare Commission can be asked for an "Independent Review" of the case. The Healthcare Commission is an independent body established to promote improvements in healthcare. If a complainant remains unhappy after local resolution and independent review then a complaint can be made to the Health Service Ombudsman, who is completely independent of both the NHS and Government.