Deprivation of Liberty Safeguards: ethical and clinical implications

The Deprivation of Liberty Safeguards were introduced in 2009 as an addition to the Mental Capacity Act 2005. This review discusses the legal impact of the Deprivation of Liberty Safeguards in the management of incapacitated patients.

The advent of the Deprivation of Liberty Safeguards had promised a significant step in the field of treatment of mentally incapacitated patients. However, in reality it has raised more questions than answers among professionals dealing with this issue. Moreover there is an inherent conflict between allowing people to make their own decisions and safeguarding the interests of people who lack the capacity to decide for themselves (Troke, 2012).

The Deprivation of Liberty Safeguards that came into effect in April 2009 were incorporated into the Mental Capacity Act 2005 via the Mental Health Act 2007 and their main aim is to ensure that people's human rights are protected in certain care environments when they are deprived of their liberty. They can be only used in hospital and care home settings. The safeguards do not apply to people under the age of 18 years or anybody residing in their own home, a carer's home or any form of supported accommodation.

Until the introduction of the Deprivation of Liberty Safeguards there were two main legal frameworks involved in the treatment of patients who fail to consent. Under the Mental Health Act 1983, 'mentally ill patients with a mental disorder of sufficient nature and/or degree can be treated without consent for their own mental health and/or safety and/or to protect others', whereas under the Mental Capacity Act 2005 mentally incapacitated patients can be detained with a view to protect them in their best interests.

The Bournewood case and how it paved the way towards the development of Deprivation of Liberty Safeguards

The Mental Capacity Act 2005 and its predecessor the Common Law Doctrine of Necessity were not originally devised to authorize any deprivation of liberty (Fennel, 2011). Mentally incapacitated patients were allowed to be admitted informally, without using the powers of the Mental Health Act 1983, provided they did not resist detention. This system left these vulnerable people practically detained in the hospital without any appropriate legal procedure or any legal right to challenge the detention, yet it was quite obvious that they would have been prevented from leaving if they had tried to do so.

The Bournewood case [*R v Bournewood Community and Mental Health Trust ex parte L* 1998] was instrumental in revealing the inadequacy of the common law and the lack of legal procedure when it came to the treatment of mentally incapacitated patients. The case was initially taken to the House of Lords and subsequently to the European Court of Human Rights as *HL v United Kingdom* (2004). The case involved Mr HL who suffered from autism and severe learning disability and as a result was unable to consent to any form of treatment. His doctor treated him under common law in a mental health inpatient unit and advised staff to stop him if he tried to abscond from the hospital. His carers questioned the doctor's decision to treat Mr HL under common law rather than following the route of detention under the Mental Health Act 1983. The European Court of Human Rights stated that the fact that the patient is not protesting does not automatically mean there is no deprivation of liberty.

Bournewood gap

In the case of Mr HL Lord Steyn acknowledged the presence of a hiatus, a gap, which has come to be known as 'the Bournewood gap'. This is a gap in the lawful detention or treatment of passively compliant yet incapacitous patients subject to a deprivation of liberty. The government decided to close the 'Bournewood gap' through amendment of the Mental Capacity Act 2005. These Bournewood safeguards, better known as Deprivation of Liberty Safeguards, were expected to protect the rights of hospital and care home patients and secure compliance with the European Convention on Human Rights.

Distinction between the Deprivation of Liberty Safeguards and the Mental Health Act 1983

The Deprivation of Liberty Safeguards were not introduced to replace the Mental Health Act 1983 (Hargreaves,

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2009). Schedule 1A of the Mental Capacity Act 2005 tries to identify situations where the Deprivation of Liberty Safeguards are inappropriate and the Mental Health Act 1983 should be used instead. This includes patients already detained under the Mental Health Act 1983 in a hospital, patients on leave or under conditional discharge from hospital detention, patients undergoing supervised community treatment or under guardianship, and finally patients who are actively protesting against their detention (Allen, 2010).

Assessment under the Deprivation of Liberty Safeguards

The Deprivation of Liberty Safeguards introduced two new schedules, A1 and 1A, into the Mental Capacity Act 2005. Authorities applying for authorizations under the Deprivation of Liberty Safeguards also have a positive obligation to take into account the past wishes and values of the incapacitated individual and his/her family, and thereby fulfil the obligations under Article 8 of the European Convention on Human Rights.

Deprivation of liberty can now be authorized legally in the case of a mentally incapacitated person over the age of 18 years, in three situations:

1. If the Court of Protection authorizes the deprivation of a person's liberty as part of a personal welfare decision (Pearce and Jackson, 2012)
2. Under the Deprivation of Liberty Safeguards procedures in Schedule A1 of Mental Capacity Act 2005 (which specifies the qualifying requirements for a Deprivation of Liberty Safeguards authorization and has been listed below)
3. In the case of the need for life-sustaining treatment, pending a court order.

The hospital authority or care home managers have to apply to the supervisory body for authorization of such deprivation of a mentally incapacitated person's liberty. The supervisory body could be the primary care trust responsible for the care or treatment or the local authority. For patients admitted in hospitals in Wales the supervisory body is the National Assembly for Wales.

There are six qualifying requirements to be fulfilled in order to grant a standard authorization for detaining a mentally incapacitated individual under the Deprivation of Liberty Safeguards.

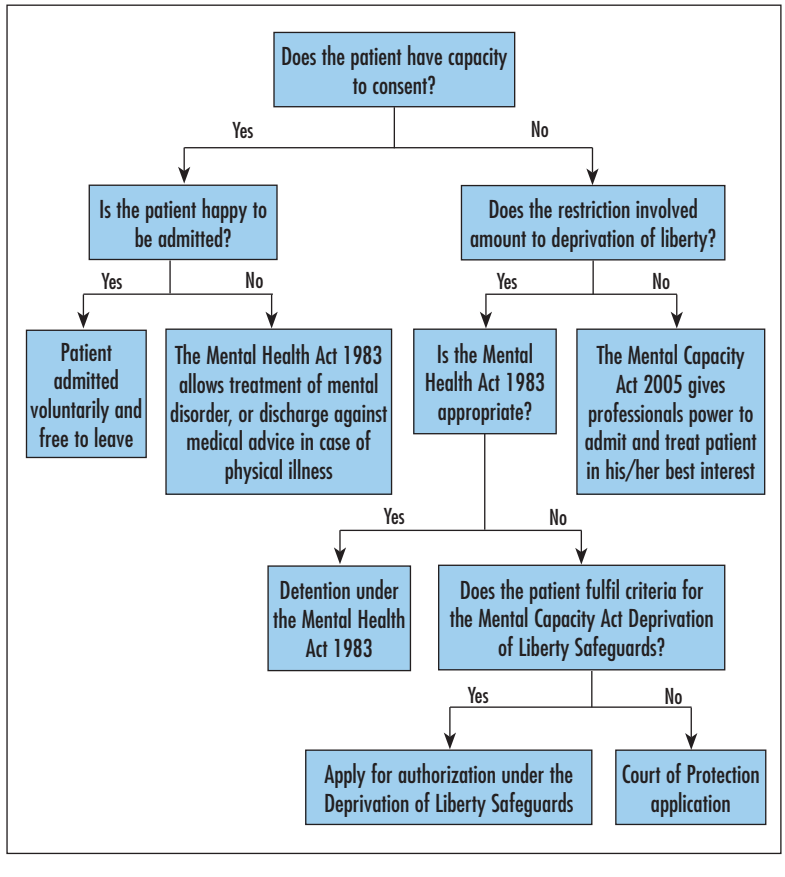
1. The age requirement: the Deprivation of Liberty Safeguards can only be applied for individual aged 18 years or over
2. The mental health requirement: the presence of a mental illness according to the Mental Health Act 1983 with the exception of learning disability, as the safeguards can be used irrespective of whether the learning disability is associated with challenging behaviour or not
3. The mental capacity requirement: it is self explanatory as the individual to be deprived of liberty ought to lack capacity relating to the issue
4. The best interest requirement: the individual needs to be detained in his/her best interest for protection of self and all other alternatives to detention should be explored before authorizing detention
5. The eligibility requirement: this clarifies whether the individual can be detained under a different statute namely the Mental Health Act 1983 or whether there is any objection on behalf of the individual
6. Finally the 'no refusals' requirement: this necessitates the consideration of any advanced decision made by the individual, which is valid or any decisions by an attorney on behalf of the patient.

An Independent Mental Capacity Advocate should be instructed by the supervisory body to represent the person under the Deprivation of Liberty Safeguards if there is no other person to consult other than that person's paid carers or professionals in charge of his or her care. Professionals should follow a step-by-step approach when dealing with patients who might lack capacity, as illustrated in *Figure 1*.

The appeal procedure

According to the European Convention on Human Rights, any individual deprived of liberty needs to have access to a court to review the detention as a matter of urgency. The mentally incapacitated person who has been deprived of his/her liberty or his/her representative can automatically appeal to the Court of Protection (Ministry

Figure 1. A guide to Deprivation of Liberty Safeguards decision making.



of Justice, 2008). Section 21A of the Mental Capacity Act 2005 empowers the Court of Protection to intervene who may thereby vary or terminate such a Deprivation of Liberty Safeguards authorization.

Dilemmas surrounding the Deprivation of Liberty Safeguards

One of the controversies regarding the Deprivation of Liberty Safeguards revolves around the concept of deprivation *vs* restriction of liberty and the factors suggesting either of them. In the case of *HL v United Kingdom* (2004) the European Court declared that the demarcation between deprivation of liberty which needs legal authorization and restriction of liberty was 'one of degree or intensity and not one of nature or substance' and it depends on several criteria including the time limit, manner of implementation, and the type and result of the deprivation. Although the amendment of the Mental Capacity Act 2005 attempted to close the so-called Bournewood gap the law failed to provide a statutory definition of 'deprivation of liberty'.

Significant case laws in this field

Cheshire West and Chester Council v P [2011] is a landmark legal case. The case involved a 39-year-old man who was born with Down's syndrome, had cerebral palsy and also suffered from cerebral vascular accidents. He was looked after by his mother from birth up until 2009 when her health started to fail. He was subsequently placed in Z house. He had no choice about his accommodation, care and treatment. The staff in the home had total control over his care, including personal care, and he was resistive to it. The particularly concerning behaviour was his habit of chewing his incontinence pads and staff had to use a body suit to prevent him doing this. Moreover, restraint was used to cope with his physical aggression.

Baker J ruled that P was deprived of his liberty. Lord Justice Munby on behalf of the Court of Appeal overturned his ruling, stating that the care was essential as a result of his illness. Lord Munby stated that P was leading a life as normal as possible with his disabilities. He ruled that the restrictions on P were 'the inevitable corollary of his various disabilities'. This judgment has been hailed as 'a victory for common sense; restrictions which are necessary to facilitate a disabled person to live a more normal life should not be seen as a deprivation of liberty' (Spencer-Lane, 2011).

P and Q v Surrey County Council [2011] is another significant case where the Court of Appeal considered the issue of objection on behalf of the incapacitated individual a pertinent factor in deciding whether there is a deprivation of liberty. This concept clashes with the judgment of the European Court of Human Rights in the case of *HL v United Kingdom* (2004) which states that an individual should not be stripped of his/her rights under the Article 5 of the European Convention on Human Rights just because he/she has not protested against his/her detention. The relevance of 'purpose' has also caused considerable confusion in this particular case. It has been argued that if the restriction imposed on the incapacitated individual is in his/her best interest then it does not amount to deprivation of liberty. The case of *P and Q v Surrey County Council* [2011] involved the removal of two young women with learning disabilities from their abusive family situation. Wilson LJ ruled that it was irrelevant to consider the purpose of detention when it comes to the point of deciding whether there is any deprivation of liberty.

Potential benefits of the Deprivation of Liberty Safeguards

The Mental Capacity Act Deprivation of Liberty Safeguards were initially welcomed with great optimism and their aims were widely accepted. The initial training made care providers more aware of their care practices and individual cases were analysed and their care plans reviewed. The care givers focussed on providing more person-centred care through allocation of more resources in an appropriate care environment. The Deprivation of Liberty Safeguards were able to transform the attitude of care givers to some extent. As a result the overall level of care has improved and it has been a positive experience from the point of view of patients. Care homes and general hospitals started getting more support from mental health teams as a result of awareness of the Mental Capacity Act Deprivation of Liberty Safeguards.

Latest developments in the Deprivation of Liberty Safeguards arena

The House of Lords Select Committee report on the Mental Capacity Act 2005 highlighted the fact that the safeguarding procedures for incapacitated people were not standardized and there is a lack of awareness among professionals dealing with these vulnerable people (House of Lords, 2014). The government fully supported the report and responded in a positive fashion, pledging more training and support for professionals and transform the attitude of society so that incapacitated individuals are treated equally and fairly (HM Government, 2014).

Moreover one practical issue that may arise is in the case of an incapacitous patient who does not agree to stay and is clearly deprived of liberty but for whom the purpose of detention is neither assessment nor treatment of mental disorder but purely for care and residence in a safe place. The Code of Practice of the Mental Capacity Act 2005 says that unresolved disputes about residence, including the person him-/herself disagreeing, should be referred to the Court of Protection to ascertain the lawfulness of such detention (Social Care Institute of Excellence, 2011). In the case of *LB Hillingdon v Steven Neary* [2011], the Judge clearly stated that deprivation of

liberty cases should be brought before the Court of Protection in a timely fashion when any doubt arises regarding the place and relevance of detention and whether the deprivation is proportionate and in the best interest of that person.

Judgment of the Supreme Court in *P v Cheshire West and Chester Council and another and P and Q v Surrey County Council* [2014]

Finally the Supreme Court's judgment in *P v Cheshire West and Chester Council and another and P and Q v Surrey County Council* [2014] have forced professionals to seriously consider deprivation of liberty in all incapacitated patients under their care (Department of Health, 2014). In these two cases appeals were made against the Court of Appeal's earlier judgments that the individuals concerned were essentially not deprived of their liberty on the grounds of normality.

The Supreme Court overruled the Court of Appeal judgment stating that the individual's compliance with care, purpose of the placement or the amount of restriction needed for relative normality were not relevant to consider whether there is deprivation of liberty. The Supreme Court judgment has been based on the universal character of the human rights. Lady Hale categorically stated:

'...what it means to be deprived of liberty must be the same for everyone, whether or not they have physical or mental disabilities'.

To comply with the Article 5 of the European Convention on Human Rights, the Supreme Court has now suggested an acid test for deprivation of liberty. The two pertinent questions to ask are whether the person is under continuous supervision and control and whether he or she is free to leave. If the answer to the first question is yes and the second question is no then the person has been deprived of liberty, even if it is done in good faith to protect and enhance quality and dignity of life of the incapacitated person.

Conclusions

This article has provided a brief review of the Deprivation of Liberty Safeguards and the case laws and recent Supreme Court judgment in this complicated area of law. Deprivation of liberty is now considered in the light of the universal nature of the Human Rights Act, irrespective of the mental or physical disability of the person. The fact that the person is deprived of his/her liberty to maintain his/her dignity and safety does not mean that there is no deprivation of liberty. In Lady Hale's words 'a gilded cage is still a cage' [*P v Cheshire West and Chester Council and another and P and Q v Surrey County Council,* 2014].

Treating professionals should be mindful of the extreme vulnerability of people who lack the capacity to make decisions regarding their care and treatment. They must follow appropriate legal regimes to uphold the patient's human rights as set out in the European Convention of Human Rights as part of their basic professional duty. **BJHM**

Conflict of interest: none.

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KEY POINTS

- Patients who lack capacity to consent to care and treatment are extremely vulnerable.
- The Mental Capacity Act 2005 Deprivation of Liberty Safeguards provide a legal framework for incapacitated patients and clinicians should review all care and treatment plans in the light of this judgment.
- Clinicians should be aware of the principles of the Mental Capacity Act and the universal nature of human rights irrespective of physical and mental disability.
- Deprivation of liberty is a complicated area of law. Clinicians should err on the side of caution, act in the patient's best interest and uphold his/her human rights.