NHS
Humber and
North Yorkshire
Integrated Care Board (ICB)

NORTH
EAST
LINCOLNSHIRE
COUNCIL
www.nelincs.gov.uk

Memorandum of Understanding (MoU)

Deprivation of Liberty in Hospital: Agreed Principles

Contents

	Page number
Agreed principles	3 - 10
Case studies	11 - 24

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

Introduction

1. This document has been agreed and adopted by the following partner organisations:

    a. NHS Humber and North Yorkshire ICB (North East Lincolnshire Place);
    b. North East Lincolnshire Council
    c. Focus;
    d. Navigo.

2. This document addresses the interface between the Mental Capacity Act 2005 ("MCA") and Mental Health Act 1983 ("MHA"). It is based on legal advice and accurately reflects the law as at March 2024. The document's purpose is to support legal compliance, foster consistency of practice and reduce disagreement between professionals. It is not intended to fetter legitimate professional discretion; however, all professionals must exercise their discretion within the boundaries set down by the law as described in this document. The aim of this document is to ensure that service users receive support in the least restrictive way and that unavoidable deprivation of liberty is lawfully authorised in accordance with the appropriate legal regime.

3. This document primarily addresses the law in relation to the deprivation of liberty of adult service users (aged 18 or over) in hospital for the purposes of care and/or treatment, referred to as 'P'. It does not address the position with regard to children under the age of 16. The position with regard to young people aged 16 and 17 is dealt with briefly at paragraph 34.

4. Practitioners are expected to follow these principles in practice. Disagreements should be escalated in accordance with the procedure described at paragraph 35 below.

Definitions

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

General points

5. All DOL in hospital must be properly authorised, otherwise it will be unlawful. Practitioners must plan proactively to avoid gaps or lapses in authorisation.

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

7. In a care/treatment setting, objective DOL is identified by applying the "acid test" set down by the Supreme Court in the case of *Cheshire West*[1].

8. Practitioners must assess whether a DOL arises, consider the best mechanism for authorising a DOL, and obtain an authorisation via the most appropriate route, except where the 2017 case of *Ferreira* applies. In *Ferreira* the Court of Appeal identified a class of exceptional cases where P's care and treatment in hospital would not amount to a DOL. These cases concern patients in acute hospitals, usually but not exclusively on ICU, who are receiving immediately necessary life-saving medical treatment[2]. However, these cases are expected to be a very small minority and in all other cases consideration must be given to whether the patient is/will be deprived of their liberty in hospital. Where the *Ferreira* exception does not apply, the guidance in this document must be followed to ensure all DOL in hospital is properly authorised.

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

    a. Detention under an appropriate section of the MHA;

    b. Authorisation of deprivation of liberty under the Deprivation of Liberty Safeguards ("DOLS"). NB: when restricting or restraining P, the MCA provides a defence to liability where P is unable to consent (and such restriction/restraint is necessary and proportionate – see s5/6), but this defence does not extend to depriving P of their liberty, without further authorisation.

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

11. Assessments of mental capacity are of supreme importance and must be undertaken with care, applying the test set out in the MCA and the guidance in the MCA Code of Practice as interpreted by case law in the Court of Protection.

    a. The question will be:

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

    b. The relevant information to be explained to P must include the nature of the confinement to which they are/will be subject[3].

---

[1] On 18 March 2024 the Law Society published its updated guidance document *"Identifying a deprivation of liberty: a practical guide"*, which is a useful resource to help identify cases of deprivation of liberty in different settings

[2] *'…any deprivation of liberty resulting from the administration of life-saving treatment to a person falls outside Article 5(1) (as it was said in Austin) "so long as [it is] rendered unavoidable as a result of circumstances beyond the control of the authorities and is necessary to avert a real risk of serious injury or damage, and [is] kept to the minimum required for that purpose"'* (para 89)

[3] *A Primary Care Trust v LDV & Ors* [2013] EWHC 272 (Fam)

12. An urgent authorisation under the DOLS will only be lawful in exceptional circumstances where the need for the deprivation of liberty is so urgent that it is in P's best interests for it to begin before a standard authorisation has been issued[4].

    a. It is perfectly legitimate to issue an urgent authorisation when P is admitted to hospital as long as the qualifying requirements for DOLS appear to be met (see below) and the need to deprive P of their liberty arises urgently either (1) before it has been possible to apply for a standard authorisation, or (2) where an application for a standard authorisation has already been made but the standard authorisation has not yet been granted.

    b. However the proper process wherever possible is to apply for a standard authorisation, and obtain that authorisation, before P is admitted and deprived of their liberty.

13. An urgent authorisation will not be lawful where it is used in circumstances that cannot reasonably be described as urgent. This will include:

    a. Using an urgent authorisation to plug avoidable gaps in MHA detention or gaps between DOLS standard authorisations;

    b. Discharging P from MHA detention before a DOLS standard authorisation has been issued and using an urgent authorisation to fill the gap[5].

14. All relevant assessments and decisions must be clearly recorded, setting out reasons. This includes documenting the reasons why a particular legal regime (MCA/DOLS or MHA) has been used to authorise the deprivation of P's liberty, applying the principles set out in this document.

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

Decision makers

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

    a. A DOLS Eligibility Assessor: when assessing whether an application for a DOLS standard authorisation should be granted;
    b. An AMHP: when considering whether an application under the MHA ought to be made;
    c. Hospital Managers: when considering whether continued use of the MHA is appropriate;
    d. A Responsible Clinician (RC): when considering whether P ought to be discharged from MHA detention;
    e. The First Tier Tribunal: when considering whether P ought to be discharged

[4] *"I emphasise that the scheme of the DOLS is that, in the vast majority of cases, it should be possible to plan in advance so that a standard authorisation can be obtained before the deprivation of liberty begins. It is only in exceptional cases, where the need for the deprivation of liberty is so urgent that it is in the best interests of the person for it to begin while the application is being considered, that a standard authorisation need not be sought before the deprivation begins"* (Baker J in *AJ (Deprivation Of Liberty Safeguards)* [2015] EWCOP 5 at paragraph 133).

[5] See further at paragraph 29 below.

from MHA detention.

17. Professionals working on hospital wards will need to consider which form of DOL authorisation appears most appropriate in the circumstances of each case and make the necessary referrals for authorisation to be granted. This will include issuing urgent authorisations where this appears to be justified applying the principles in this document.

MHA or MCA/DOLS?

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

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

20. Where P lacks capacity to take decisions as to whether they should be in hospital to receive care and treatment, in the majority of cases there will be no choice between use of the MHA or use of DOLS as only one option for authorisation will be available – see paragraphs 22-27 below.

21. Where P lacks capacity, the DOLS may be used where it appears likely that P will meet all 6 qualifying requirements in hospital[6]. The six qualifying requirements are:

    a. age;
    b. mental health;
    c. mental capacity;
    d. best interests requirement;
    e. eligibility;
    f. no refusals.

22. The DOLS cannot be used where P is ineligible for the DOLS.

23. Ineligibility is determined by applying Schedule 1A MCA. Schedule 1A describes 5 "cases" in which P will be ineligible for the DOLS. One of those ("Case E") is where P is not already detained under the MHA but:[7]:

    a. P is, or it is proposed that P will be, a "mental health patient"; i.e. they will be accommodated in a hospital for the purpose of being given medical treatment for mental disorder[8];

    AND

    b. P objects to being a mental health patient; i.e. P objects to receiving some or all of the proposed medical treatment for their mental disorder, or to being in hospital to receive that treatment;

[6] The qualifying requirements are defined in Schedule A1 MCA with ineligibility further addressed in Schedule 1A MCA.
[7] This is a summary of Case E as set out in para 2 of Schedule 1A MCA. This sequence of questions for identifying whether a person falls within Case E was approved by Mrs Justice Theis in *Manchester University Hospital NHS Foundation Trust v JS & Others (Schedule 1A Mental Capacity Act 2005)* [2023] EWCOP 33
[8] The definition of "mental health patient" is in paragraph 16 of Schedule A1 MCA. See page 3 of this document for the definitions of "mental disorder" and "medical treatment for mental disorder".

AND

c. P could be detained under the MHA; i.e. in the opinion of the decision maker an application in respect of P could be made under section 2 or 3 MHA, and if an application were made P could be detained in hospital under section 2 or 3 MHA.

24. In some cases P (who lacks capacity) will have a need for treatment for both mental and physical health. It will be necessary to determine whether P's proposed detention will be primarily for mental health or for physical health purposes. A "but for" test[9] should be applied. The decision maker should look at:

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

    The question will be:

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

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

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

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

26. "Medical treatment" and "mental disorder" are widely defined for these purposes and "medical treatment for mental disorder" does not only mean treatment for psychiatric illness in a mental health unit. P may also be ineligible for the DOLS in other (non-psychiatric) hospital settings when receiving treatment for other (non-psychiatric) conditions. "Mental disorder" and "medical treatment for mental disorder" are defined on page 3 above. The MHA Code of Practice lists at paragraph 2.5 examples of what may be deemed "mental disorder".

27. Where P is ineligible for DOLS for the reasons set out in paragraphs 22-26 above, the DOLS cannot be used and the MHA must be used if P is to be deprived of their liberty in hospital.

28. In a minority of cases where P lacks capacity, P may be both eligible for DOLS and potentially detainable under the MHA. In these circumstances Chapter 13 of the MHA

[9] As per *GJ v The Foundation Trust* [2009] EWHC 2974 (Fam)

Code of Practice must be followed to determine which regime should be used.

Discharge from MHA detention onto DOLS in hospital

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

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

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

Practical points

30. An application for a DOLS standard authorisation may be made in any case where it appears that all 6 qualifying requirements are likely to be met (remember that one of the qualifying requirements for DOLS is that P must not be ineligible to be detained using DOLS). The application can be made up to 28 days before the standard authorisation is required. Applications should be made as far ahead of time as possible to allow the greatest opportunity for the assessments to be conducted and the authorisation granted before the deprivation of liberty commences.

31. Where P is under s2 MHA and a DOLS standard authorisation is applied for, this application will be prioritised by the Supervisory Body in light of the short maximum duration of the s2 authority. All such applications should be pressed as urgent with the Supervisory Body. If no standard authorisation is granted before expiry of the s2, consideration will need to be given to the use of s3 MHA to authorise any continued DOL in hospital. There must be no gap in authorisation, otherwise any ongoing DOL will be unlawful. See paragraph 29 above.

32. Where P is to be discharged from hospital and it is known that P will be discharged to a registered care setting (even though the precise destination may be unknown) practitioners should advise the DOLS team as soon as possible so that arrangements can be made and assessments can be completed quickly once the destination is confirmed. Where P will be discharged to a non-registered setting (e.g. supported living, P's own home) an application for a community DOL authorisation will need to be made to the Court of Protection ASAP as part of planning for P's discharge. Where P is detained under the MHA in hospital it may be possible to use section 17 leave to facilitate a move whist the standard authorisation or court order is awaited.

    a. This MOU should be read in conjunction with Navigo's policy in relation to the granting of leave of absence from hospital under section 17 MHA.

    b. That policy sets out the processes to be followed where P will be deprived of

their liberty in the community whilst on section 17 leave. It also makes clear that there is no requirement for the hospital to keep a bed open for P whilst they are on section 17 leave.

33. A Mental Health Act assessment for the purposes of considering detaining under section 3 MHA a patient who is currently under section 2 MHA, or for considering renewal of a section 3 MHA detention, does not need to take place in a hospital. The patient can be seen and assessed for these purposes whilst in the community on section 17 leave of absence from hospital if deemed appropriate.

Young people aged 16 and 17

34. The deprivation of liberty in hospital of a young person aged 16 or 17 must also be authorised in order to be lawful. However the options are different than for adult patients:

    a. The DOLS cannot be used for this patient cohort as the DOLS only apply to those aged 18 and above[10].
    b. The options for authorising DOL for a 16 or 17 year old are:
        i. MHA detention;
        ii. Court of Protection order;
        iii. High Court order (because the High Court still has jurisdiction until P turns 18).
    c. All deprivation of liberty of a 16 or 17 year old must be authorised by one of these mechanisms, without gaps in authorisation.
    d. The MHA can be used for this patient cohort in the same way as for adults. The same principles and working practices should be applied.
    e. If the MHA appears not to be an option practitioners should take legal advice urgently and make an application either to the Court of Protection (which has jurisdiction if P lacks capacity) or to the High Court (which has jurisdiction whether or not P has capacity) for an order authorising the deprivation of P's liberty. Applications can be made urgently if necessary. Do not delay.

Escalation

35. Disputes regarding choice of regime should be resolved peer to peer in the first instance, with support from their respective line managers where necessary. Where resolution fails at this level, disputes will be managed as follows:

    a. The dispute will be referred to a specially convened virtual dispute resolution panel, which will comprise:
        i. the staff members in dispute, who will attend to succinctly present their differing perspectives, and
        ii. at least three of the five following staff members (at least one of which must not be employed by Navigo):
            - Navigo's Medical Director
            - Navigo's MCA lead
            - The AMHP lead
            - Focus' Head of Safeguarding
            - North East Lincolnshire's Principal Social Worker

Disputes must be referred to and resolved by the panel, ideally, within 24 hours.

    b. Where the panel is unable to resolve a dispute, reference will be made to the

[10] This is the age requirement as defined in Schedule A1 MCA.

ICB's Mental Capacity Act Strategic Lead (or in his absence, to the ICB's Policy and Practice Development Lead). The Strategic Lead may decide to take legal advice where necessary, to ensure that there is no delay to authorising a deprivation of liberty.

Case studies to support application of MoU

William

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

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

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

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

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

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

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

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

Proposed answer

We suggest that the MHA should be used for William.

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

Mina

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

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

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

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

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

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

Proposed answer

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

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

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

Janice

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

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

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

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

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

Proposed answer

There appears to be no proper authorisation for the continued deprivation of Janice's liberty once her section 2 has expired.

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

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

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

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

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

Melanie

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

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

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

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

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

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

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

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

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

<u>Proposed answer</u>

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

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

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

It is contradictory to deem Melanie informal but also issue an urgent authorisation.
The urgent authorisation will not be lawful because: 1) the circumstances are foreseeable and not urgent; 2) Melanie will almost certainly be ineligible for the DOLS.

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

Alan part 1

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

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

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

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

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

Proposed answer

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

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

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

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

Alan part 2

You now learn that Alan is being covertly medicated.

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

Proposed answer

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

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

Charlie

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

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

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

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

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

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

Proposed answer

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

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

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

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

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

Iris

Iris is 78 years old and lives in her own home with her daughter. She has a long history of depression. Her mental state deteriorates but her daughter prevents health and social care services from seeing Iris. There are significant concerns for Iris's welfare at home.

A warrant is obtained under section 135 MHA and Iris is assessed under the MHA. She is admitted to a psychiatric unit detained under section 2 MHA. Iris is unable to express her views about the admission to hospital but she is fully compliant with coming to hospital. She also complies with the treatment she is offered on the psychiatric ward.

After a few days Iris's mental state improves and she is better able to engage in conversations with staff. She says she is happy to stay in hospital and to continue receiving treatment for her depression as recommended by her RC. She is considered to lack mental capacity at all relevant times with regard to being in hospital and receiving care and treatment there for her mental disorder. She is not yet considered ready for discharge and if she attempted to self-discharge staff would prevent her from leaving.

How can Iris's continuing admission be authorised from this point on?

Proposed answer

In these circumstances it may be possible for either the MHA or the DOLS to be used to authorise Iris's continued deprivation of liberty in hospital. Iris lacks mental capacity to consent to being hospital for treatment. The proposed treatment will amount to medical treatment for her mental disorder and so she will be a "mental health patient". It appears that she continues to meet the section 2 MHA criteria for detention. However there appears to be no evidence that Iris objects either to being in hospital or to receiving treatment there for her mental disorder. In that case she will not be ineligible for the DOLS and therefore DOLS will also be a possible option, in addition to the MHA, to authorise her continued deprivation of liberty.

Iris's RC will need to apply the guidance in chapter 13 of the MHA Code of Practice to determine which regime (MHA or MCA) would be the most appropriate to authorise DOL for Iris from this point on.

There must be no gap in authorisation, otherwise Iris will be unlawfully detained.

If the RC concludes that the DOLS would be the more appropriate legal framework for Iris (s)he must not discharge Iris from the MHA before a DOLS standard authorisation has been granted. It will not be lawful to use an urgent DOLS authorisation here because the circumstances are not urgent or unforeseen. The MHA must continue to be used until a standard authorisation is granted.

Note paragraph 30 in this MOU. Where P is under section 2 MHA and a DOLS standard authorisation is applied for, this application will be prioritised by the Supervisory Body in light of the short maximum duration of the section 2 authority. All such applications should be pressed as urgent with the Supervisory Body. If no standard authorisation is granted before expiry of the section 2, consideration will need to be given to the use of s3 MHA to authorise any continued DOL in hospital.

Iris part 2

The facts are the same as above except that Iris initially resists this admission to hospital and has a documented history of objecting, albeit not consistently, to being in hospital and being treated for her depression.

Would your answer be different? If so, how?

Proposed answer

On these facts Iris will be ineligible for the DOLS because there is evidence of objection to receiving some or all of the proposed medical treatment for her mental disorder, and to being in hospital to receive that treatment. The DOLS will therefore not be available for Iris and the MHA must continue to be used to authorise the deprivation of her liberty.

Angela

Angela is 16 years old and has been admitted to an acute mental health unit under section 2 MHA after a serious attempt at self-harm. She is diagnosed with adjustment disorder and presents with significant emotional dysregulation. She is now approaching the end of the 28 day section 2 period and her presentation remains variable on the ward; her mood can be very variable and she regularly engages in self-harm and suicidal actions including intentional overdoses, tying unsuspended ligatures and head-banging. Some of these behaviours are new and her RC is concerned that she may be copying behaviours she has seen other patients engage in on the ward. She dislikes being in hospital.

The RC is concerned that hospital is not an appropriate environment for Angela as it is appears to be making her behaviours worse. She is keen for Angela to be discharged and is struggling to justify continued detention under the MHA. Angela is not on any medication and her management on the ward consists of general nursing and behavioural support only. However the LA says that no suitable community placement is currently available and there is a long waiting list. The risks to Angela in the community will also be significant and she needs a specialist secure therapeutic placement to keep her safe.

How do you advise the RC?

Proposed answer

Whilst Angela remains in hospital the continued deprivation of her liberty will need to be properly authorised. She is coming to the end of her section 2 period and the RC will need to consider what should come next. Angela's mental capacity should be assessed for relevant purposes, however the DOLS will not be available to authorise Angela's continued stay in hospital because of her age. The RC will need to give careful consideration to the section 3 MHA criteria, in particular whether it is necessary for her to remain in hospital and whether appropriate treatment is available for her there. The Court of Protection will have jurisdiction if Angela lacks mental capacity but may not be able authorise the deprivation of her liberty if she is ineligible applying Schedule 1A MCA. The only alternative would be for the High Court to be asked to authorise the DOL using its inherent jurisdiction.

Kate

Kate is 45 years old. She has mild to moderate learning disabilities and Emotionally Unstable Personality Disorder. Her mental disorder is said to be chronic, enduring and severe, characterised by abnormally aggressive and seriously irresponsible behaviour.
A couple of years ago, Kate was admitted to a psychiatric hospital, and has been detained there under section 3 MHA ever since. Recently Kate suffered from bleeding at her injection site on provision of a depot injection and investigations revealed that she had leukaemia. Kate was admitted to her local acute hospital trust on section 17 leave of absence from the psychiatric hospital and she began immediate chemotherapy treatment there. Kate has been the subject of repeated restraint since admission, and staff at the psychiatric hospital from which she is on leave are supporting acute colleagues to help manage Kate's behaviours.

It is agreed that Kate lacks capacity to consent to chemotherapy treatment for leukaemia and that it is in her best interests to have it. Acute hospital staff are concerned that the level of restraint required to treat Kate amounts to a deprivation of liberty.

The team is unclear which statute (MCA or MHA) should authorise Kate's care and treatment arrangements in the acute hospital, taking into account:

a) the type of treatment Kate is receiving;
b) the level of restraint necessary for her to have it;
c) that she is on s17 leave to the acute hospital trust, from her psychiatric hospital.

What do you advise?

Proposed answer

When granting section 17 leave Kate's RC has the option of directing that Kate remain in custody whilst she is on leave at the acute hospital[11].

If a custody requirement is directed by the RC this will authorise Kate's ongoing deprivation of liberty whilst she is on leave to the acute hospital. She will fall within Case A in Schedule 1A MCA because she remains under section 3 MHA and is detained in a hospital (the acute hospital) by virtue of the custody requirement; she will therefore be ineligible for a DOLS authorisation at the acute hospital. Because she remains under section 3 MHA the provisions of Part IV MHA will apply and she can be treated without her consent for her mental disorder and its symptoms or manifestations[12]. The RC will direct that treatment and must take care to ensure that (s)he only directs medical treatment for Kate's mental disorder.

If a custody requirement is not directed by the RC the deprivation of Kate's liberty at the acute hospital will need to be authorised by some other means. She will not be ineligible for the DOLS in the acute hospital because although she remains under section 3 MHA she is not currently detained in a hospital (because she is on leave with no custody requirement). Therefore the acute hospital must obtain an authorisation under the MCA for the deprivation of her liberty.

Leukaemia could not be said to be a symptom or manifestation of Kate's mental disorder and so treatment for leukaemia could not be directed by the RC under the MHA. Kate is resistant to treatment for leukaemia to the extent that she needs to be restrained to undergo it in her best interests. The acute hospital will need to consider whether an application should be made to the Court of Protection for orders and declarations approving the leukaemia treatment plan

[11] Section 17(3) MHA
[12] Section 63 MHA.

in Kate's best interests[13]. It should be noted though that the Court will not be able to authorise the deprivation of Kate's liberty in the acute hospital if a section 17(3) custody requirement has been directed by the RC because she will be ineligible for such an order, just as she is ineligible for the DOLS.

The acute hospital trust and the mental health trust should work together to devise an appropriate treatment plan for Kate whilst she remains at the acute hospital, taking into account the medical treatment she will need for both her leukaemia and her mental disorder, and to consider an application to the Court of Protection.

[13] Applying the guidance issues by Hayden J in January 2020.

David

David becomes mentally unwell and is detained in an acute mental health unit under section 2 MHA. His mental state improves and he is deemed ready to leave hospital. He is assessed as lacking capacity with regard to decisions about his future residence and care. An interim registered care home placement (Care Home A) is found for him and he is granted section 17 leave to live there whilst further thought is given to where he should live and be looked after longer term. As he nears the end of his 28 day section 2 detention period he is brought back into the inpatient unit to be assessed for section 3 MHA detention. He is detained under section 3 MHA and then granted section 17 leave again to go back to Care Home A. A few days later Care Home A applies for a DOLS standard authorisation, however before a standard authorisation is granted he is moved from Care Home A to Care Home B in his best interests. Care Home B immediately applies for a DOLS standard authorisation.

David remains on section 17 leave of absence from hospital under the MHA in Care Home B until a standard authorisation is granted two weeks later. He is then discharged from MHA detention.

How could this situation have been handled differently?

Proposed answer

Care Home A should have applied for a DOLS standard authorisation as soon as it was known that David would be moving there. David will not be ineligible for DOLS in Care Home A; he will fall within Case B in Schedule 1A MCA as someone who is subject to section 2 MHA but on leave of absence from hospital (so not detained there). Therefore he can be under the DOLS whilst also on section 17 leave, and Care Home A has an obligation under Schedule A1 MCA to make the DOLS application. This should not have been delayed.

David did not need to be brought back to hospital to be assessed for detention under section 3 MHA. He could have been assessed under the MHA in the community.

When he goes back to Care Home A under section 17 leave he is again not ineligible for the DOLS, for the same reason. There is no good reason for the further delay.

Care Home B is right to apply immediately for a DOLS standard authorisation and should have issued an urgent authorisation at the same time.

The delay in applying for a DOLS standard authorisation may have resulted in section 3 MHA being used unnecessarily. The use of section 3 MHA triggers eligibility for section 117 aftercare.