

Housing LIN INFORMATION SHEET: MCA – no. 2

The Mental Capacity Act 2005: Lawful restraint or unlawful deprivation of liberty?

This information sheet is one of four that accompanies the Housing LIN factsheet Housing Provision and the Mental Capacity Act 2005

Whilst the new Act permits individuals to carry out acts for or on behalf of an incapacitated person where these are in connection with the incapacitated person's care or treatment, it does not provide any statutory protection for a deprivation of the person's liberty. In addition any action which might result in a restraint on the incapacitated person's freedom will not attract protection from liability unless:

- the person taking action reasonably believes restraint is *necessary* to prevent *harm* to the person who lacks capacity, and
- the amount or type of restraint used and the amount of time it lasts must be a *proportionate response* to the likelihood and seriousness of harm. This will mean using the least intrusive type and minimum amount of restraint to achieve a specific outcome in the best interests of the person who lacks capacity.

Restraint is defined as using force or threatening to use force to secure the doing of an act that the person resists, or the restriction of the person's liberty of movement, whether or not s/he resists. The Code of Practice recommends restraint is used only as a last resort or in exceptional circumstances. The way in which it might be used must be recorded in a person's care plan or the decision maker's other records and all instances when restraint is actually used should be recorded in the case notes or file.

It can be difficult for providers to determine whether a course of conduct they deem necessary to prevent harm amounts to restraint, and therefore lawful if they can establish it is proportionate, or to a deprivation of liberty and therefore outside the protection given by the Act. The distinction is important from a practical point of view as the Code makes clear that anyone depriving an incapacitated person of their liberty is outside the protection of the Act regardless of whether they are a public authority. Deprivation of liberty will usually amount to false imprisonment, a civil law wrong, so anyone doing it could be made liable for any damages which could be awarded to the incapacitated person – unless a Court finds there to have been a lawful excuse.

Unfortunately neither the Act or Code of Practice further define a deprivation of liberty, but case law does offer some guidance as to what could amount to a deprivation of liberty. The European Court of Human Rights in HL v The United Kingdom identified the following as factors contributing to deprivation of liberty:

- physical or chemical restraint was used to admit a person resisting admission
- professionals exercised complete and effective control over care and movement for a significant period
- professionals exercised control over assessments, treatment, contacts and residence
- the person would be prevented from leaving if they made a meaningful attempt to do so
- a request by carers for the person to be discharged to their care was refused
- the person was unable to maintain social contacts because of restrictions placed on access to other people
- the person lost autonomy because they were under continuous supervision and control.

In a recent case, DE [2006], the High Court considered as a preliminary issue whether the respondent authority had deprived Mr E of his liberty. Mr E had been accommodated by the local authority, following emergency intervention to safeguard his welfare. Without any formal assessment of capacity, and despite the presumption of capacity, even for people who have had a stroke, the authority kept Mr E in the home, no doubt because they did not consider it feasible to provide for him if he were to return to the care of his wife, who had mental health difficulties of her own. Mr and Mrs E made repeated requests that he be allowed to return home; however, the local authority relied on the doctrine of necessity as authority to refuse this request over a 9 month period and informed Mrs E that they would notify the police were she to make attempts to remove him from their care.

The judge stated that a person can be as effectively “deprived of his liberty” by the misuse or misrepresentation of even non-existent legal authority as by locked doors and physical barriers, and held, in this case, that such a misrepresentation of the law had amounted to a deprivation of liberty as the local authority were aware that it would have the effect of preventing Mr E in getting help from his wife and from exercising his freedom to leave. The absence of locked doors or chemical restraint and freedom to see relatives on the premises did **not** mean that there was no deprivation of liberty.

Therefore for a deprivation of liberty to occur there must be both an *objective* element, i.e. a person’s confinement in a particular restricted space for a not negligible length of time and a *subjective* element, namely that the person has not validly consented to the confinement in question. When considering the *objective* element, account must be taken of the **type, duration, effects and manner of implementation of the measure** in question. The distinction between a deprivation of and a *restriction* upon liberty is merely one of degree or intensity, and **not one of nature or substance**. The key factor is whether the person **is, or is not, free to leave**. Do those treating and managing the person exercise **complete and effective control** over the person’s care and movements? As regards the *subjective* element, where a person **has** capacity, consent to their confinement may be inferred from the

fact that the person does not object. Express refusal of consent by a person who has capacity will be determinative of this aspect of 'deprivation of liberty'. No such conclusion may be drawn in the case of a patient **lacking** capacity to consent. The fact that an incapacitated person may have 'given himself up' to the regime does not mean that he has consented to his detention.

Much can be done by providers and commissioners of care through best practice to reduce the risk of deprivation of liberty by minimising restrictions and ensuring that decisions are taken involving the person concerned and their carers. Elements of good practice that are likely to assist in this, and in avoiding the risk of legal challenge, include:-

- Ensuring that decisions are taken (and reviewed) in a structured way and that reasons for decisions are recorded. Protocols for decision-making should include safeguards against arbitrary deprivation of liberty.
- Effective, documented care planning (including the Care Programme Approach, Single Assessment Process, Person Centred Planning, and Unified Assessment as relevant) for such people, including appropriate and documented involvement of family, friends, carers (both paid and unpaid) and others interested in their welfare.
- Proper assessment of whether the patient lacks capacity to decide whether or not to accept the care proposed. In accordance with the principles of the Mental Capacity Act 2005, and Chapter 3 of the related Code of Practice, a person should not be taken to lack capacity to make a decision unless they have been given support to make the decision in question. If the person has capacity to do so, they should be supported to make decisions about their own care. It is also important to identify if a person's condition has deteriorated and they no longer have capacity to consent, and to ensure that decision-making complies with the Mental Capacity Act 2005, including consideration of whether they are deprived of liberty.
- Ensuring, as required by the fifth principle of the Mental Capacity Act 2005, that alternatives to admission to hospital or residential care are considered and that any restrictions placed on the person while in hospital or residential care are kept to the minimum feasibly required and necessary in all the circumstances of the case.
- Ensuring appropriate information is given to the person themselves and to family, friends and carers. This would include information about the purpose and reasons for the admission, proposals to review the care plan and the outcome of such reviews, and the way in which they can challenge decisions (eg through the relevant complaints procedure). The involvement of local advocacy services where these are available should be encouraged to support patients and their families, friends and carers.
- Taking proper steps to help the person retain contact with family, friends and carers. If, exceptionally, there are good reasons why maintaining contact is not in the person's best interests, those reasons should be properly documented and explained to the people they affect. It should be made clear how long the restrictions will be maintained and how the decision can be challenged.
- Ensuring both the assessment of capacity and the care plan are kept under review. It may well be helpful to include an independent element in the review. Such a

second opinion will be particularly important where family members, carers or friends do not agree with the authority's or provider's decisions. But even where there is no dispute, all involved must ensure their decision-making stands up to scrutiny and complies with the principles of the Mental Capacity Act 2005.

Conclusion

Despite the provisions of the Mental Capacity Act, distinguishing between restraint and deprivation of liberty, and the express withholding of the s5 protection from liability for acts amounting to a deprivation of liberty, and the Bournewood proposals for care home or hospital deprivation of liberty currently undergoing Parliamentary consideration, it is now clear that the High Court or Court of Protection **can** authorise deprivation of liberty without acting in breach of the European Convention or the UK's Human Rights Act. Effectively, the *Bournewood* gap has now been closed by the development of the declaratory relief jurisdiction.

The precedent for this proposition is the judgment of Mr Justice Munby in *Sunderland City Council v PS and CA*, 2007. But the Court must itself comply with the MCA and the Human Rights legislation, including principles of proportionality and necessity. This means that judicial authorisation is sought for deprivation of liberty, attempts must always be made to identify ways to meet the person's needs in a less restrictive way. A judicial authorisation for deprivation of liberty is not an alternative to the proper application of the rest of the Mental Capacity Act 2005.

The judge suggested that if one needs to deprive someone of their liberty

- i) The detention must be authorised by the court on application made by the proposed detainer **before** the detention commences.
- ii) Subject to the exigencies of urgency or emergency the evidence must establish unsoundness of mind of a kind or degree warranting compulsory confinement.

In other words, there must be evidence establishing at least a prima facie case that the individual lacks capacity and that confinement of the nature proposed is appropriate.

- iii) Any order authorising detention must contain provision for an adequate review at reasonable intervals, in particular with a view to ascertaining whether there still persists unsoundness of mind of a kind or degree warranting compulsory confinement.

He implied that granting what's called 'liberty to apply' to court on notice could achieve this sort of review.

Other Information sheets in this series include:

1. The Mental Capacity Act 2005: Substitute Decision-making and Agency
3. The Mental Capacity Act 2005: Paying for necessities and pledging credit
4. The Mental Capacity Act 2005: Statutory Duties to Accommodate

