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Mental Capacity Act 2005, Deprivation of Liberty Safeguards Assessments (England) - Second report on annual data, 2010/11

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Executive Summary

The Mental Capacity Act Deprivation of Liberty Safeguards (MCA DoLS), which came into force on 1 April 2009, provide a legal framework to ensure people are deprived of their liberty only when there is no other way to care for them or safely provide treatment. They were introduced as an amendment under the Mental Health Act 2007 but form part of the Mental Capacity Act.

Basic quarterly figures on authorisations under the new arrangements have already been released for quarter 1 to 4 2010/11earlier in 2010/11. A few PCT's and LAs have informed us of changes to the total number of applications made to them when the quarterly figures were published. These corrections have been reflected in the annual publication so annual totals may not equal the sum of the quarterly totals.

This report provides information on uses of the legislation across the whole year from 1 April 2010 - 31 March 2011. This report also references the expected figures included in the planning assumptions made by the Department of Health[1].

Key findings:

- The total number of applications made was still much lower than expected for the second year (8,982 in England compared with the number predicted for in England and Wales[1] which was around 18,600). This compares to the 7,157 applications made in 2009/10; just over 34 per cent of the predicted number for that year.
- The number of successful applications resulting in an authorisation to deprive a person of their liberty was about the expected number (4,951 in England compared to the 5,000 predicted for in England and Wales[1]), though a much higher percentage of applications than expected were successful (55% compared with the predicted 25%[1]). In the previous year 3,297 applications were approved – a 46% approval rate compared to the 25% expected.
- About 2% of applications that were not authorised involved situations where the person was nevertheless judged as being in a situation that amounted to a deprivation of liberty. In these cases the hospitals and care homes could be acting illegally, if that person was not swiftly cared for or treated in less restrictive circumstances. This is half the percentage in 2009/10 (4%).
- Of those authorisations that were granted, more then half (55%) were for a person who lacked capacity because of dementia.
- 57% of those applications made to a Local Authority were granted when applying for a deprivation of liberty compared to 50% in Primary Care Trusts.
- Authorisations granted for people in care homes were generally for longer periods than for people in hospitals (62% of authorisations granted by Local Authorities were for more than 90 days compared with 23% of Primary Care Trust authorisations).
- There is a big difference in the number and rate of applications in different parts of England, with the highest number and rate of applications being made in the East

[1] Impact Assessment of the Mental Capacity Act 2005 deprivation of liberty safeguards to accompany the Code of Practice and regulations

Midlands (1,644 applications and 46 applications per 100,000 population) compared to the England rate (22 applications per 100,000 population) and the lowest number of applications made in the North East (579) with the lowest rate being in the East of England with just 13 applications per 100,000 population.

Introduction

The Deprivation of Liberty Safeguards, which were introduced as amendments to the Mental Capacity Act 2005 on 1 April 2009, are designed to protect vulnerable people against overly restrictive care while they are in hospitals or care homes.

This second annual report on Deprivation of Liberty Safeguards uses data provided every three months by Primary Care Trusts (PCTs) and Local Authorities (LAs), the organisations responsible for managing the process for authorising requests to deprive someone of their liberty in 2010/11. Requests from care homes are handled by LAs and requests from hospitals are handled by PCTs.

This report draws on data published earlier this year, covering four quarters data for the year 2010-11 to provide analysis of the whole year's data, as well as a commentary on what the statistics show for the second year since implementation of the new legislation. The report also includes some new analysis on the data which covers the two year period that the legislation has applied to. Appendix A lists the analyses of the whole year's data which provides the information for this report. These tables are provided in an accompanying Excel spreadsheet. Information about the process to deprive someone of their liberty can be found in Appendix B.

The information in this report will be of interest not only to those charged with implementing and monitoring the new safeguards, but also to individuals who are at risk of being deprived of their liberty and their families. Information about the number of assessments and characteristics of people for whom applications were made will also be of interest to PCTs and LAs, who have to ensure that requests for authorisation for a deprivation of liberty are handled promptly and correctly and that resources are in place to do so.

Before any new legislation is introduced an impact assessment is undertaken, which in this instance includes estimating how many people will be affected and how many applications will need to be assessed. This report has used this analysis to show the comparison of actual to planned volumes of activity.

Background information about the implementation of the Deprivation of Liberty Safeguards

In 2008 the then Government's impact assessment, see Appendix A, for the new legislation included an estimate that approximately half a million people in England were living in institutions and lacked capacity to consent to the arrangements for their care or treatment. These are considered to be the group potentially at risk of being deprived of their liberty.

Within this population by far the largest group is judged to be people with dementia. However it also includes people with severe learning disabilities and people with a mental disorder who lack capacity, as well as others who lack capacity, for example because of acquired brain injury. The Department of Health estimated that approximately 1 in 10 might be subject to a degree of restriction, to protect them from harm, and in some cases these restrictions might constitute a deprivation of liberty. A combination of factors, such as being constantly subject to one to one supervision or being prevented from taking trips out with friends and relatives could add up to a deprivation of liberty.

The number of likely applications for assessment to see if a person's situation constituted a deprivation of liberty was considered to be largely dependent on the judgment of individual hospital and care home managers and on how they assessed the distinction between a restriction of someone's liberty and a deprivation of liberty. It seemed unlikely that applications for authorising a deprivation of liberty would be made for the entire 'at risk' population of people in institutions.

On the basis of consultation with interested parties the Department of Health estimated that there would be about 21,000 applications in the first year in England and Wales resulting in fewer than 5,000 authorisations. They also estimated that the applications would be split 80/20 between LAs and PCTs, because more of the at risk population were in care homes than in hospital. They also anticipated that more applications would be made for women than for men because there are more women than men in the over 75 age group and older people were more likely to be 'at risk' because of dementia.

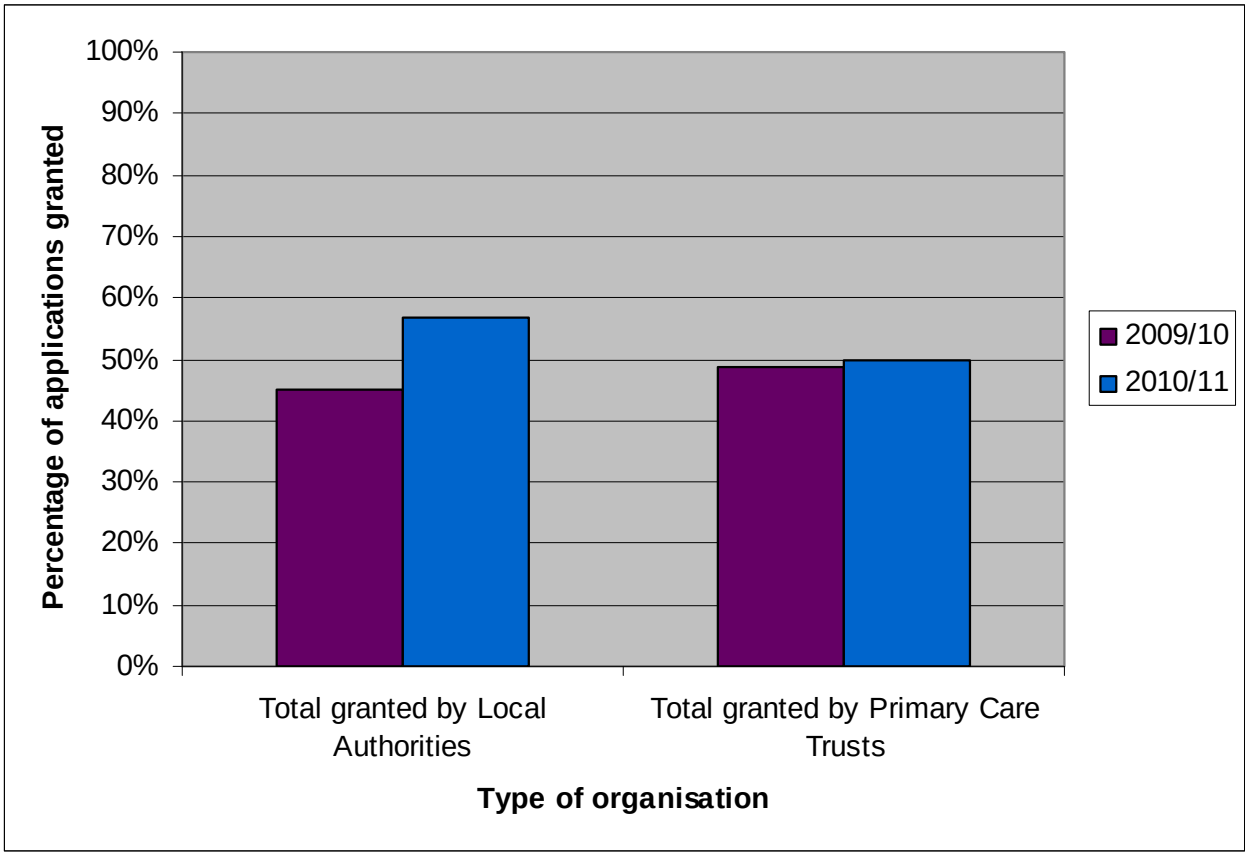
Chapter 1: Number of applications and characteristics of the people for whom applications were made

Number of applications and outcome of assessments

Between April 2010 and March 2011 8,982 applications for assessment were made by managing authorities of which 4,951 resulted in an authorisation for a deprivation of liberty being granted.

6,708 applications were made to LAs and 2,274 to PCTs. In 2009/10, PCT's had a higher rate of granted applications of 49% compared to LAs which had a 45% granted rate. This year, LAs have had a higher rate with a 57% granted rate compared to a 50% granted rate in PCTs. This can be seen in Figure 1 below.

Figure 1: Percent of applications granted by type of organisation, by year



Data source: Table 1 in Appendix A – Annual DoLS supporting table 2010/11

The total percentage of applications granted has increased from 46% in 2009/10 to 55% in 2010/11. This is still significantly higher proportion than expected (planners expected less than a quarter of applications to result in an authorisation). However the total number of applications and of authorisations was still much lower than expected. See Table 1 below.

Table 1: Department of Health planning figures compared with actual number of applications

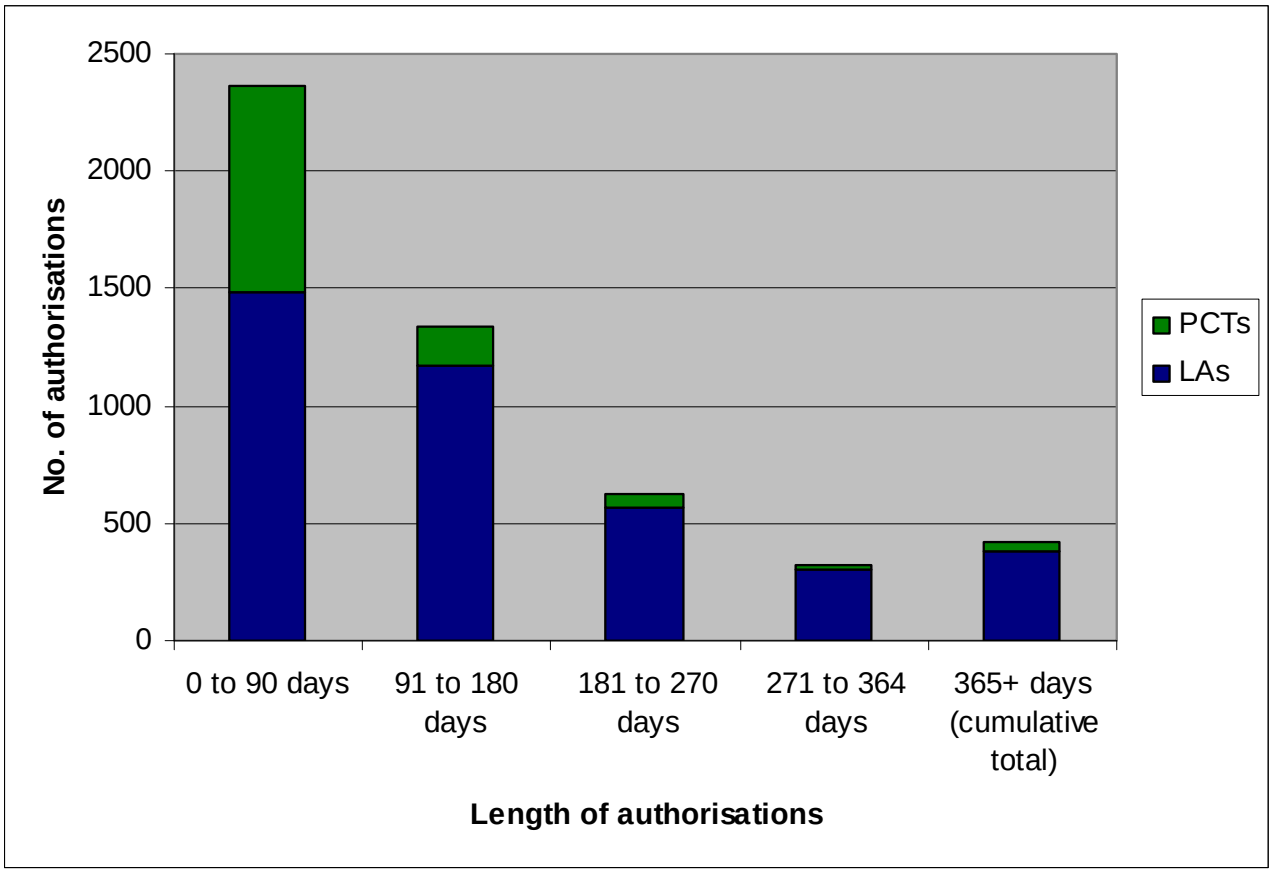
	DH planning (2010/11)			Actual (201011)		
	Total completed	Granted	Not granted	Total completed	Granted	Not granted
England and Wales	**18,600**	**25%**	**75%**			
England total				**8,982**	**55%**	**45%**
% received by LAs	80.0%	25%	75%	75%	77%	72%
%received by PCTs	20.0%	25%	75%	25%	23%	28%

There are a number of possible reasons for this discrepancy, which could include a failure to return data about all applications, however every supervisory body returned data for every quarter and so it is unlikely that data quality is the main reason.

Nearly half (47%) of authorisations were granted for a period of between 0 and 90 days and this has remained the same since 2009/10. PCTs granted a greater proportion of all their authorisations for a period of up to 90 days only, whereas LAs granted the majority of their authorisations for more than 90 days as shown in Figure 2 below. 76% of all the PCT authorisations were for 0-90 days, up from 67%, and 62% of LA authorisations were for periods of more than 90 days, up from 60%. This trend suggests that authorisations for people in care homes are generally likely to be for longer periods than for people in hospitals.

The maximum length of an authorisation is twelve months. Where a full year's authorisation has ended and is followed up immediately with a new authorisation managing authorities are instructed to record these as 365 days or more. This category also includes multiple shorter authorisations with a cumulative authorisation period of over one year. The percentage of people in England who have been subject to a granted authorisation/have had extensions that exceed a year, has increased to 8% up from 5%. See table 2 in the supporting excel spreadsheet, Appendix A.

Figure 2: Total number of authorisations granted by type of organisation, by length of authorisation in 2010/11

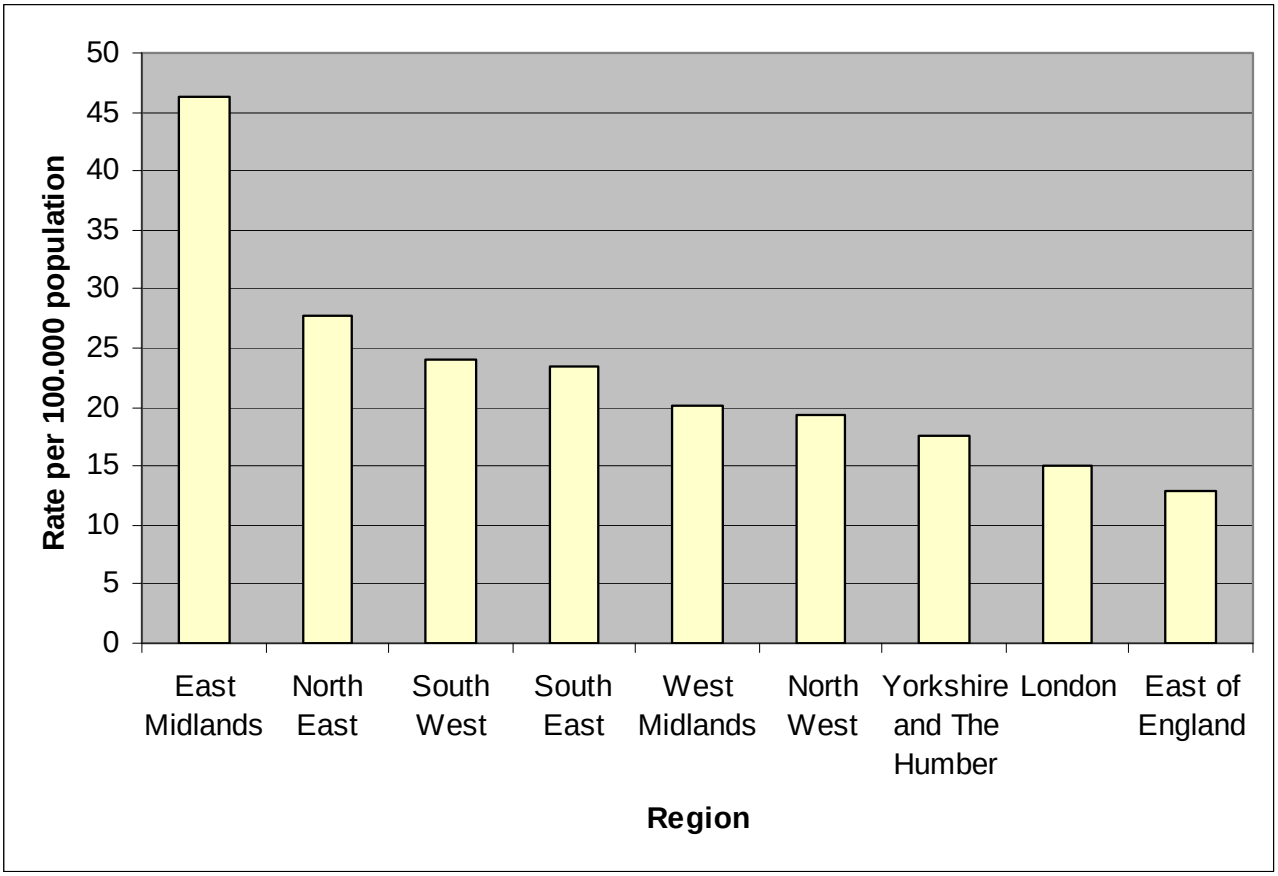


Data source: Table 2 in Appendix A – Annual DoLS supporting table 2010/11

Regional variations

The region with the most applications was the East Midlands. In 2009/10 it received 17% of all applications and in 2010/11 this increased to 18%. The North East was the region with the smallest number of applications in both years with 6% of the total number of application in 2009/10 and 2010/11. If population is taken into account, then the East Midlands also had the highest rate of applications increasing this year to 46 per 100,000, as shown in Figure 2 below, from 35 per 100,000 in 2009/10 and is now more than double the England rate of application figure which was 22 per 100,000 in 2010/11. For half the regions the rate of application was less than half the East Midland rate. Although the overall numbers are small this suggests that there is variation across the country with regard to the extent to which the new legislation is being used.

Figure 3: Rates of applications completed per 100,000 by region for 2010/11



Data source: Table 3 in Appendix A – Annual DoLS supporting table 2010/11

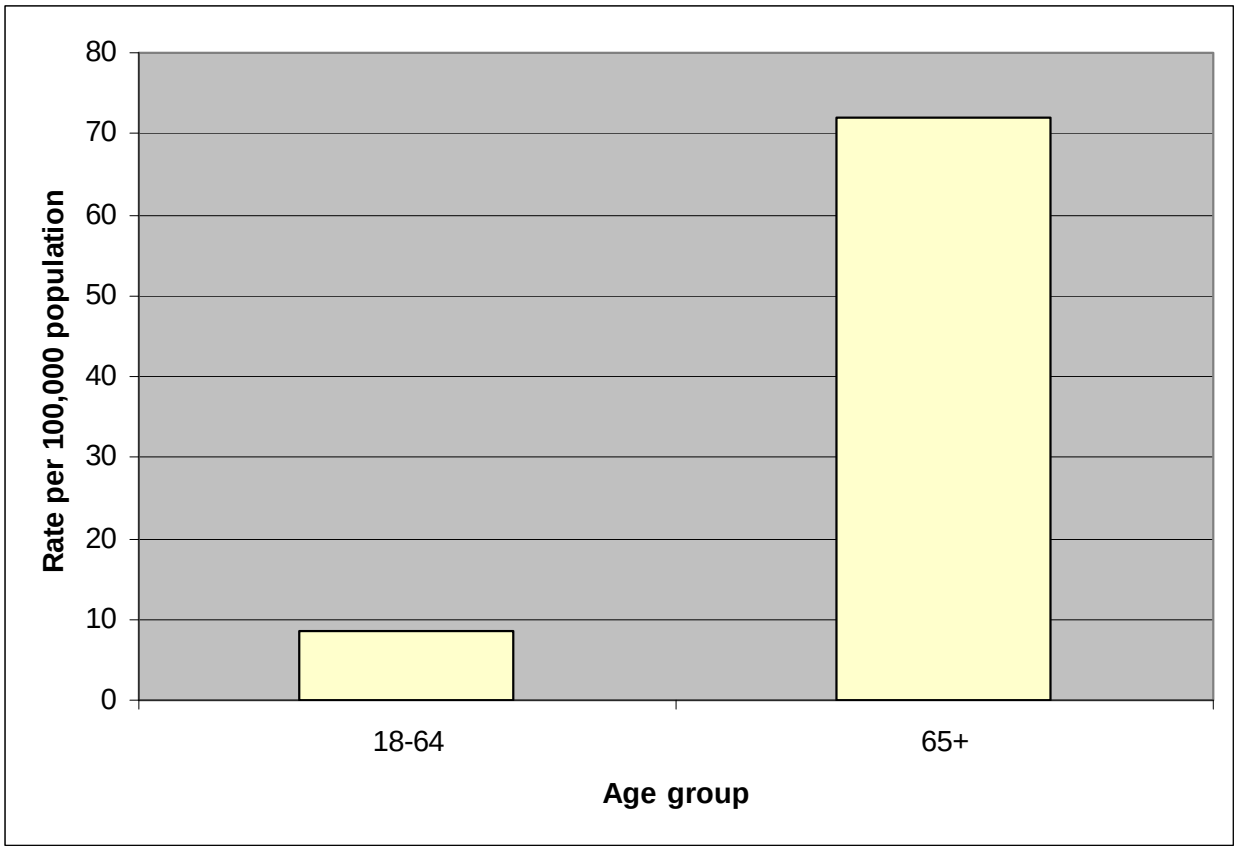
Characteristics of people for whom applications were made

The data supplied by supervisory bodies included information about the age, gender, ethnic group, religion and sexual orientation of people for whom applications were made. Total figures for the year, presented in Table 4 of the supporting Excel spreadsheet, listed in Appendix A, show that:

- 69% of applications were for people aged 65 or over.
- The rate of applications per 100,000 population was 8 times higher for the 65 and over age group, compared with the 18-64 age group, as shown in Figure 4 below.
- There were 618 more applications for women than men but the rate of applications per 100,000 population were similar with 21 per 100,000 for men and 23 per 100,000 for women.
- The proportion of applications received for people from each ethnic group was consistent with the make up of the population as a whole, except in the Asian or Asian British group where the proportion of applications was lower, as shown in Figure 4 below.
- The religion or faith group of the person for whom the application was made was recorded for 68% of applications and for 400 applications the religion was neither Christian nor Not Stated.

- In the minority ethnic groups and the non Christian religion and faith groups, the proportions of applications authorised was slightly higher than the in majority White ethnic group and Christian / No religion stated groups. However the numbers are too small to be statistically significant.
- Over 97% of applications were recorded with a sexual orientation of heterosexual or not known. See Table 4 in the supporting excel spreadsheet, Appendix A.

Figure 4: Rates of applications completed per 100,000, by age group for 2010/11



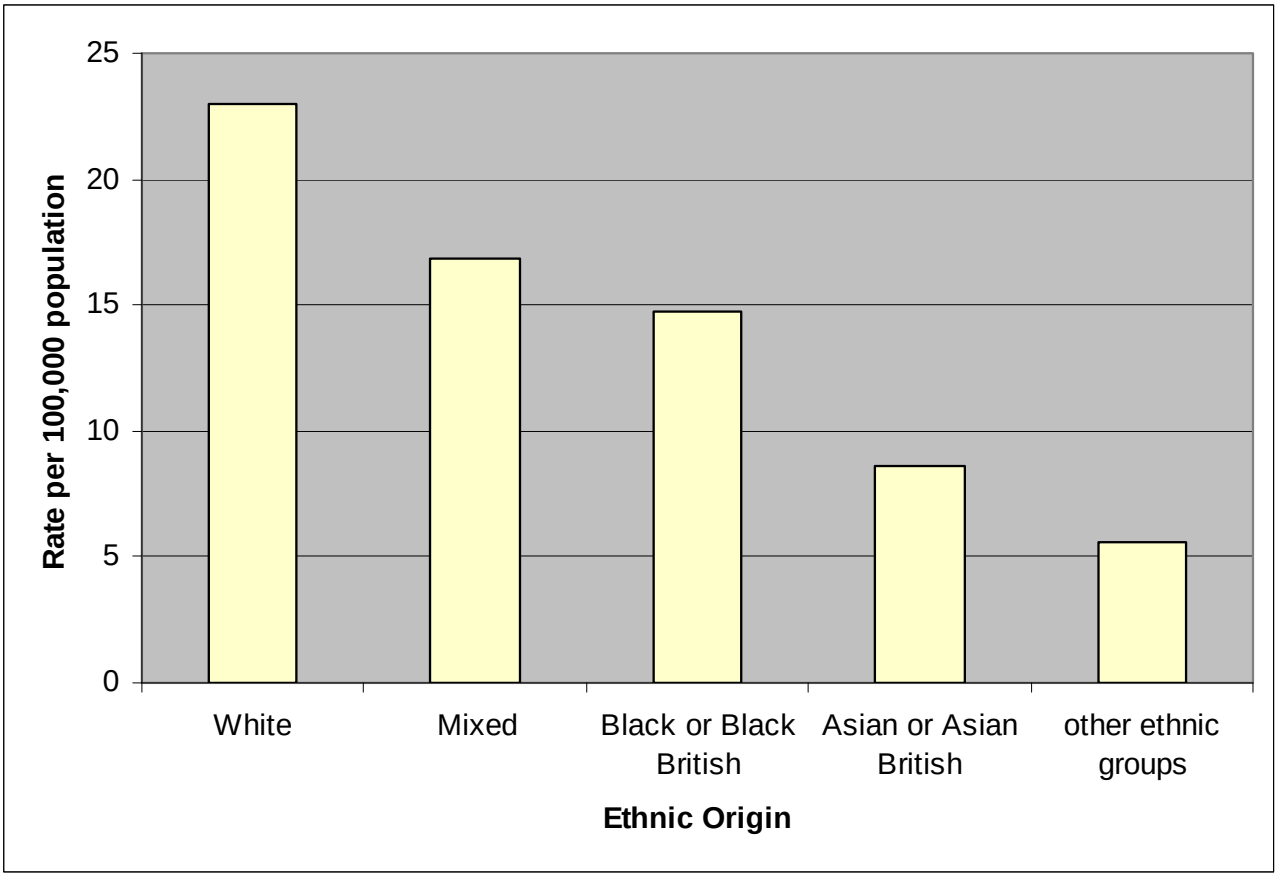
Data source: Table 4 in Appendix A – Annual DoLS supporting table 2010/11

The Code of Practice for implementing the deprivation of liberty safeguards draws attention to the need to ensure that the provisions of the Mental Capacity Act are applied fairly to all groups and not in a way that discriminates on the basis of age, gender, ethnic group, religion or sexual orientation.

As in the first year's figures, these second year's do not appear to show any evidence of discriminatory practice from the point of view of equalities and the numbers for the smaller groups are too small to lead to statistically significant conclusions.

However it is potentially interesting that, whilst official statistics about uses of the Mental Health Act have consistently shown disproportionate rates of detention for some minority ethnic groups, there is no evidence here that any ethnic groups are being disproportionately deprived of their liberty under the Mental Capacity Act.

Figure 5: Rate per 100,000 of applications completed by ethnic origin for 2010/11



Data source: Table 4 in Appendix A – Annual DoLS supporting table 2010/11

One of the differences between the two Acts, both of which can result in a deprivation of liberty, is that the Mental Capacity Act is used when a person lacks capacity to make decisions about a wide range of treatment or care. The Mental Health Act can be used when a person has capacity, but does not consent to treatment, or where a person lacks capacity to consent to treatment only for a mental disorder.

Chapter 2: Factors contributing to the application for a Deprivation of Liberty and the outcome of the assessment

The data returned by supervisory bodies includes information about the disabilities that contribute to a person needing to be assessed, the type of application that has been made and the outcome of the application. Summary data for the whole year is presented in Table 5 of the supporting Excel spreadsheet, listed in Appendix A.

Disability causing lack of capacity

Supervisory bodies are required to record the disability of the person who is undergoing an assessment. The categories are 'physical disability, frailty and/or sensory impairment', 'mental health' and 'learning disability'. In quarter 1 2010/11 more than one category could be applied to a single person's application and dementia is available as a distinct category within the overall mental health category. From quarter 2 onward, it is only possible to have one disability per person. The person's primary disability, the reason the application is being made for, should be recorded on the application. For this reason, the analysis has been performed for both quarter 1 on its own and for quarters 2, 3 and 4 for 2010/11 and can be seen in Table 5a and 5b in the supporting Excel spreadsheet.

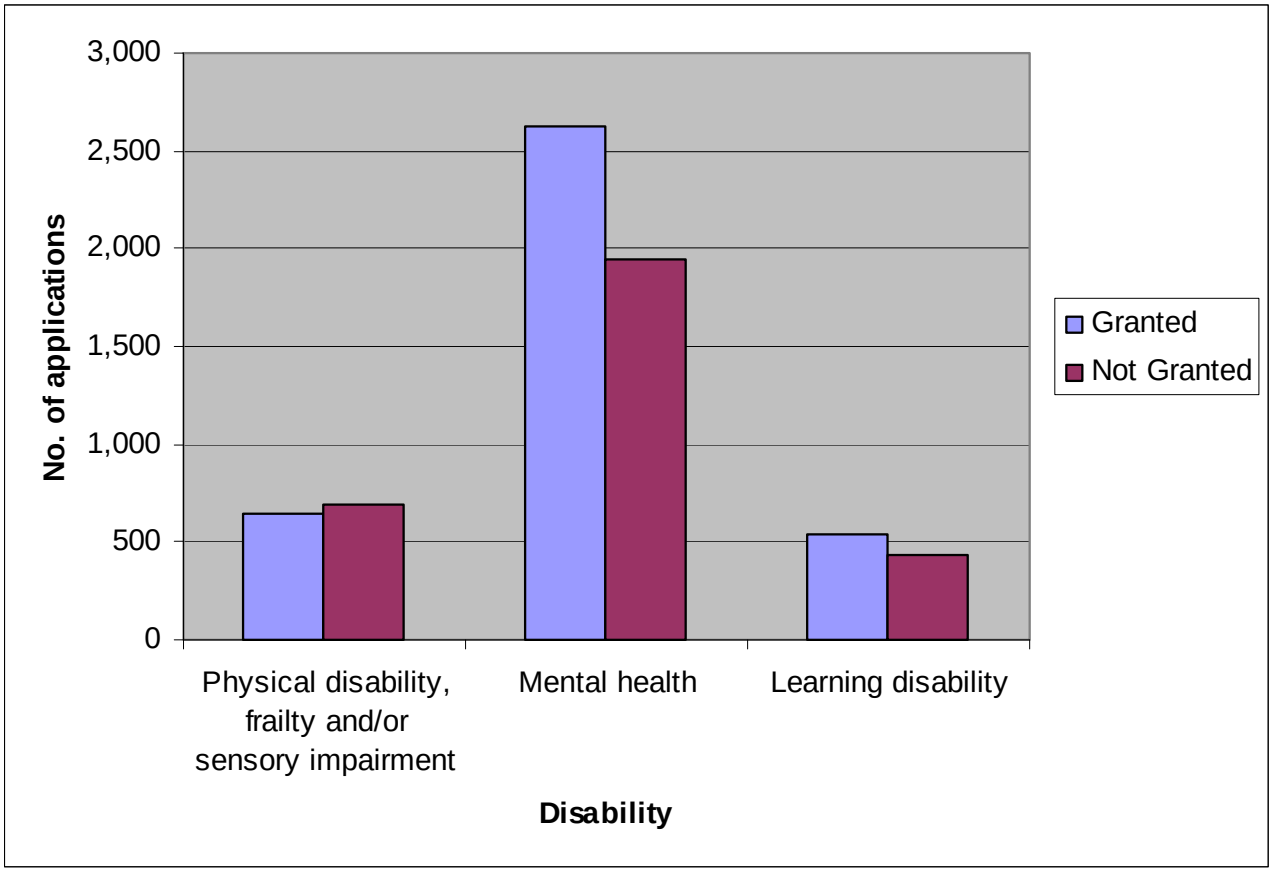
Due to this change the analysis in this report looks at the three quarters data, quarter 2 to quarter 4 2010/11.

Of the total applications completed in quarter 2 to 4 in 2010/11, 66% were for people with a disability categorised as a mental health issue, as shown in Figure 6 below, with physical disability, frailty and/or temporary illness being the next largest distinct group, 20%, followed by learning disabilities, 14%.

Looking at the sub groupings, as can be seen in table 5b in the supporting Excel worksheet, the dementia sub-group of Mental Health accounted for 52% of all applications making dementia the main reason a deprivation of liberty was applied for.

Of the applications that were granted, Mental Health was again the highest category for a deprivation of liberty to be granted with dementia again accounting for more then half of the granted applications, 55%.

Figure 6: Total number of applications by outcome, by disability in 2010/11



Data source: Table 5b in Appendix A – Annual DoLS supporting table 2010/11

Requests made by third parties in 2010/11

In some cases a third party (such as a social worker, nurse or care worker), rather than a hospital or care home manager, can raise a concern that a deprivation of liberty may be taking place. Table 2 below shows that 154 applications were raised in this way and they were split proportionately 85/15 between LAs and PCTs. This is decrease on the 2009/10 value where 226 cases caused a 3rd party to raise a concern.

Of the 154 total applications, 99 (64%) of these requests led to a full assessment. This is approximately the same ratio as 2009/10 when 65% led to an assessment.

Table 2: Numbers of third party requests made to assess whether there is an unauthorised deprivation of liberty by type of organisation

Type of Organisation	Total third party requests	Of which led to full assessments	% of requests which led to full assessment
England total	**154**	**99**	**64.3%**
Total by LAs	131	84	64.1%
Total by PCTs	23	15	65.2%

Applications that were not authorised

Compared with 2009/10 when 54% of applications were not granted, under half the applications made this year (45%) were not authorised. In 81% of cases the reason for the application being turned down was recorded as being because the application did not meet the 'best interests' requirement. Not meeting the best interests requirement category also includes cases where there was no deprivation of liberty and other reasons such as death during the application process as once an application has been started and the managing authority informed it must be completed.

Table 6, in the supporting Excel spreadsheet listed in Appendix A, shows that PCTs continued to reject a larger proportion of applications than LAs on the grounds that the eligibility criteria were not met – so a larger proportion of the applications from hospitals were rejected on the grounds of eligibility than from care homes. In such a situation, it could be that the Mental Health Act was a more appropriate instrument for depriving someone of liberty and it is possible that some of these people were subsequently detained in hospital under the Mental Health Act.

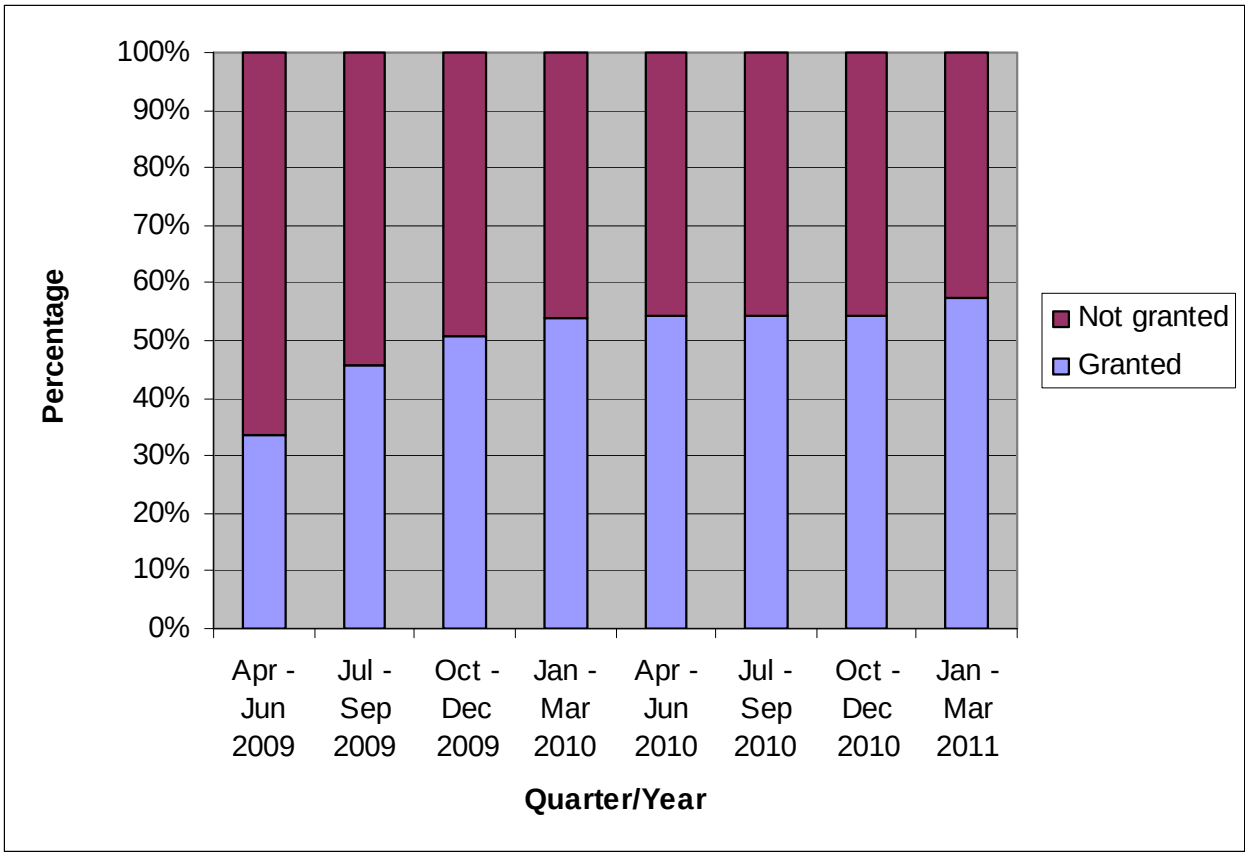
In 2010/11, out of 4,027 applications that were not authorised, there were 78 cases where the person with responsibility for assessing the person's best interests judged that the person was being deprived of their liberty, but it was not in their best interests. This is less then half the number in 2009/10 when 168 people were deprived of their liberty but not in their best interests. Since the application was not authorised, these people were at risk of being illegally deprived of their liberty, if that person was not swiftly cared for or treated in less restrictive circumstances.

Chapter 3: Implementation of the new safeguards

The data returned by supervisory bodies provides some interesting information about the way in which the legislation is being implemented.

Figure 7 below shows that the proportion of applications that resulted in an authorisation increased consistently across both years with 33% of applications successful in quarter 1 2009/10 when the legislation was first introduced and 57% successful in quarter 4 2010/11.

Figure 7: Percentage of authorisations granted or not granted by quarter



Data source: Table 7a in Appendix A – Annual DoLS supporting table 2010/11

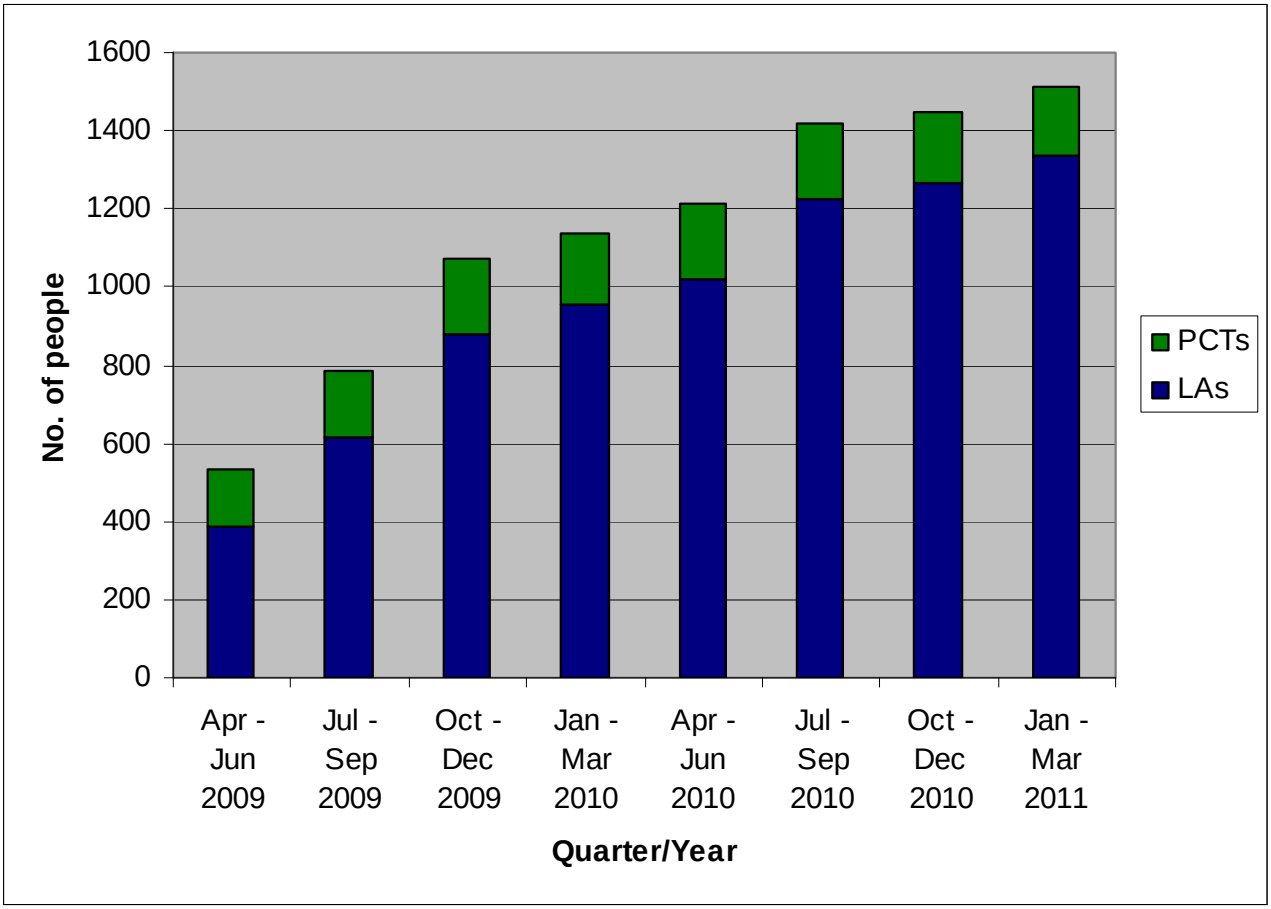
Total figures for the year presented in table 7 of the supporting Excel spreadsheet listed in Appendix A show that a larger proportion of applications made to LAs were authorised compared to PCTs.

The data received each quarter also shows the number of people subject to a deprivation of liberty authorisation at the end of the quarter. The increase in the number of authorisations granted each quarter (and shown in Figure 7 above) suggests there might be a corresponding increase across the year in the number of people subject to an authorisation at the end of each quarter and this is shown in Figure 8.

The number of people subject to deprivation of liberty at the end of each of quarter has consistently risen. The number of people subject to a deprivation of liberty at the end of quarter 4 2010/11 is approximately three times the number in the first quarter 2009/10 when the legislation was introduced. Comparing number of people at the end of quarter 4 2009/10

to the number subject to a deprivation of liberty at the end of quarter 4 2010/11, the number has increased by 40% as a year on year comparison.

Figure 8: Total number of people subject to a deprivation of liberty at the end of each quarter, by organisation type



Data source: Table 8b in Appendix A – Annual DoLS supporting table 2010/11

Urgent authorisations

Although assessments made following an urgent application increased in this second year by over 1,000 applications, the percentage of total applications made by an urgent application has decreased from 69% to 67%. In each case a person was deprived of their liberty for the 7 days allowed for the processing of a standard authorisation. Compared to 2009/10 when over half of these applications were rejected, in 2010/11 more then half these urgent authorisations were subsequently granted.

Depriving someone of their liberty is an infringement of the Human Rights Act if is not lawfully authorised and it is right that an authorisation should be applied for where there is a risk that the restrictions placed on a vulnerable person constitute a deprivation of liberty. However, the high number of urgent authorisations in the first year and the subsequent slight fall in overall ratio in the second year, as well as the reduction in number of applications not granted but a deprivation of liberty still occurring as noted in Chapter 2, might be because the lack of understanding about the boundary between protective restrictions and an outright deprivation of liberty and how these should be applied, is starting to be understood.

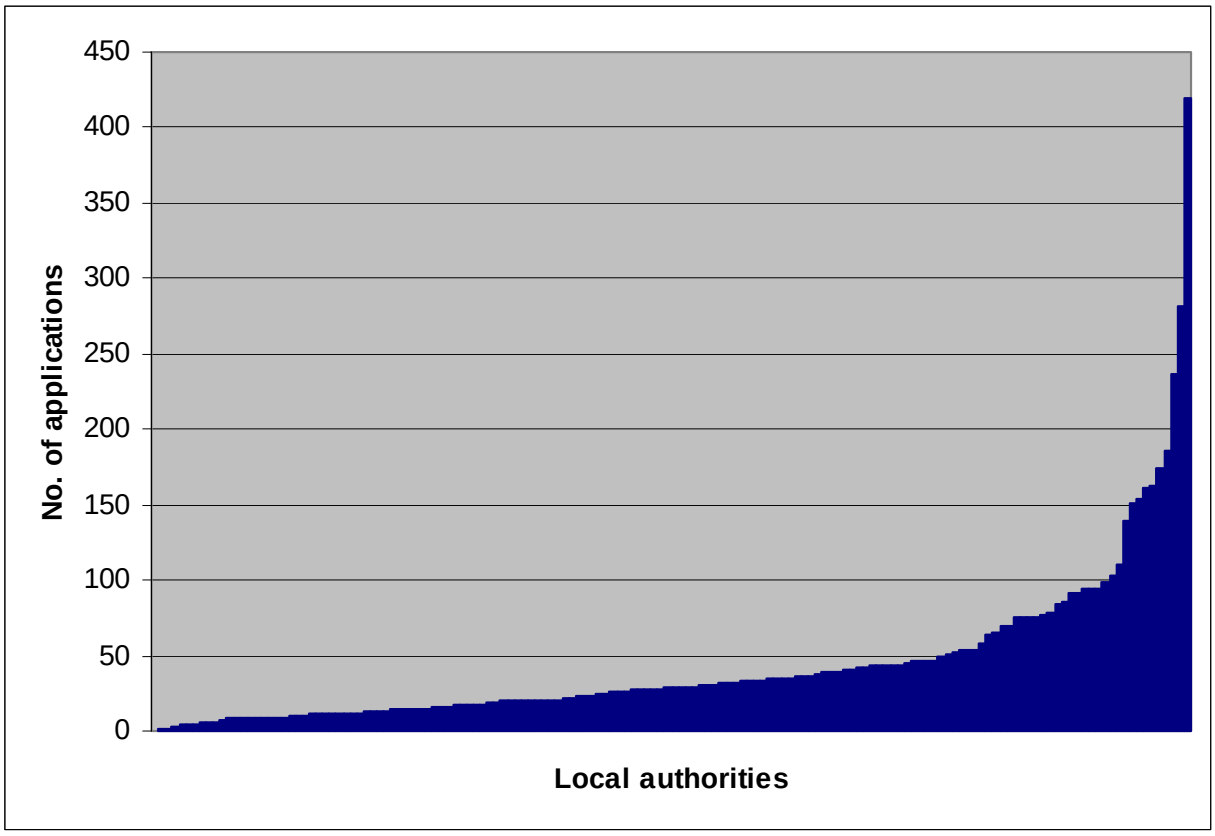
Table 3: Outcome of standard authorisation assessments that were required by urgent authorisations by quarter

Quarter	Total	Granted		% Not Granted		%
Apr - Jun 2009	1,246	462	37.1%	784	62.9%	
Jul - Sep 2009	1,137	529	46.5%	608	53.5%	
Oct - Dec 2009	1,316	641	48.7%	675	51.3%	
Jan - Mar 2010	1,275	631	49.5%	644	50.5%	
Apr - Jun 2010	1,422	709	49.9%	713	50.1%	
Jul - Sep 2010	1,580	803	50.8%	777	49.2%	
Oct - Dec 2010	1,509	752	49.8%	757	50.2%	
Jan - Mar 2011	1,502	811	54.0%	691	46.0%	

Differences in the way the new arrangements are being implemented across the country

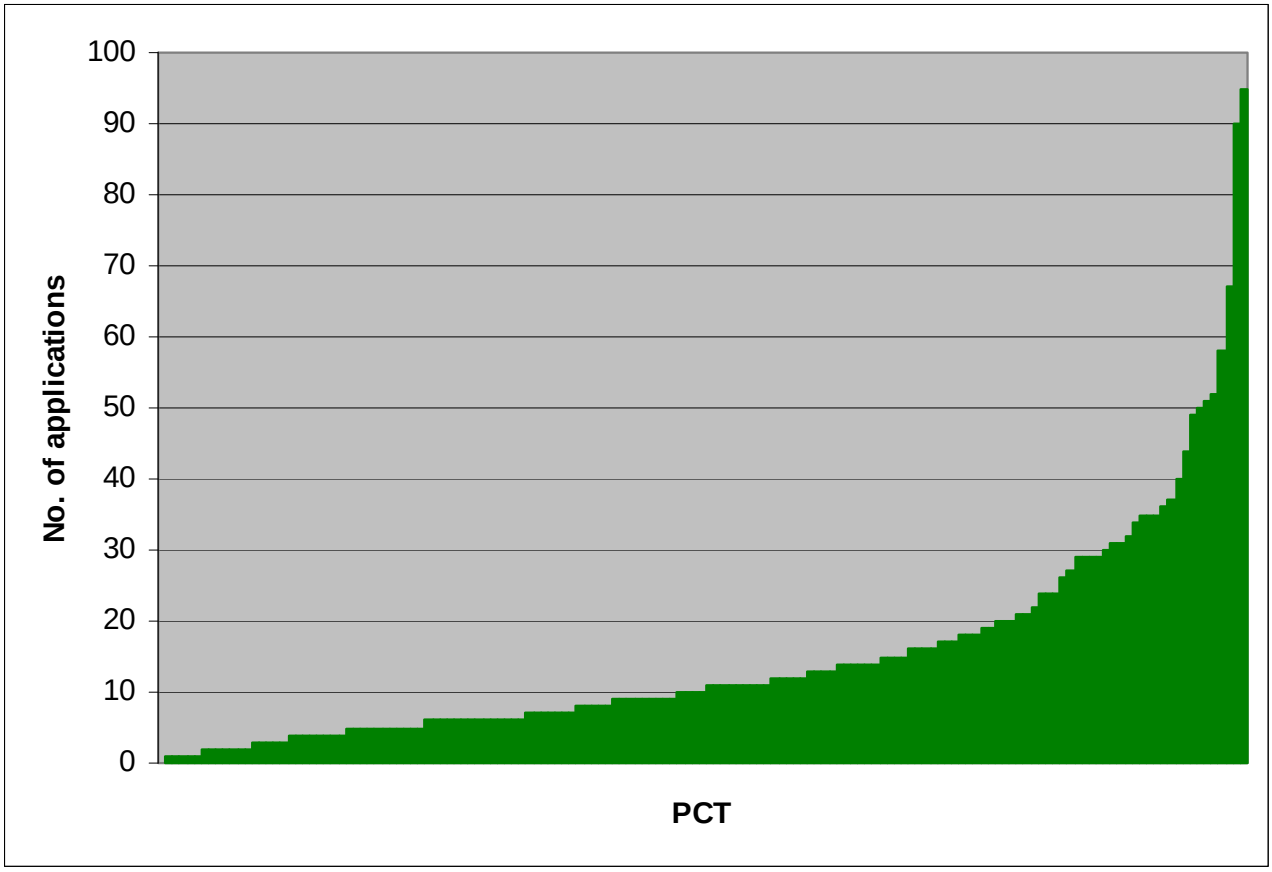
The majority of LAs and PCTs received applications to deprive someone of their liberty. Only one LA and one PCT made nil returns. The largest number of applications, from both PCTs and LAs, were in Leicestershire, who also made the most application of both LAs and PCTs in 2009/10. The scatter graphs below show that the majority of LAs received less than 50 applications in the year and the majority of PCTs received less than 15 applications.

Figure 9: Total number of application made to LAs in 2010/11



Data source: Table 9 in Appendix A – Annual DoLS supporting table 2010/11

Figure 10: Total number applications made to PCTs in 2010/11



Data source: Table 10 in Appendix A – Annual DoLS supporting table 2010/11

Tables 9 and 10 in the supporting Excel document, listed in Appendix A, displays the number of applications made to each organisation. This should provide local stakeholders with relevant information to support any investigation of how the new arrangements are being implemented locally and whether there are any issues of training, communication or practice that need addressing.

Appendix A

List of Tables in the supporting Excel document and links to other supporting documents

List of Tables

The following tables can be in the supporting Excel document which can be found here - www.ic.nhs.uk/pubs/mentalcapacity1011annual

Table 1:	Number of authorisations granted or not granted, 2010/11 by type of organisation and region
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Table 9:	Number of authorisations granted or not granted 2010/11 by Local authority
Table 10:	Number of authorisations granted or not granted 2010/11 by Primary Care Trust

References and related publications

Impact Assessment of the Mental Capacity Act 2005 deprivation of liberty safeguards to accompany the Code of Practice and regulations - http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_084982

Quarterly analysis of Mental Capacity Act 2005, Deprivation of Liberty Safeguards (DoLS) Assessments (England) –
Quarter 1 2010/11 - http://www.ic.nhs.uk/pubs/mentalcapacity1011
Quarter 2 2010/11 - http://www.ic.nhs.uk/pubs/mentalcapacity1011q2
Quarter 3 2010/11 - http://www.ic.nhs.uk/pubs/mentalcapacity1011q3
Quarter 4 2010/11 - http://www.ic.nhs.uk/pubs/mentalcapacity1011q4

The NHS Information Centre publishes official statistics about uses of the Mental Health Act in the following annual releases:

Mental Health Bulletin - www.ic.nhs.uk/pubs/mhbmhmds0910

*In-patients formally detained in hospitals under the Mental Health Act 1983 and patients subject to supervised community treatment - http://www.ic.nhs.uk/pubs/inpatientdetmha0910

*Guardianship under the Mental Health Act 2003 – http://www.ic.nhs.uk/pubs/guardianmh10

*These publications are National Statistics.

Appendix B

About DoLS and the application process

The Mental Capacity Act Deprivation of Liberty Safeguards (MCA DoLS), which came into force on 1 April 2009, provide a legal framework to prevent the unlawful deprivation of a person's liberty occurring and were introduced into the Mental Capacity Act 2005 through the use of the Mental Health Act 2007.

The safeguards protect people who are vulnerable to overly restrictive care whilst in a hospital or care home (across statutory, independent and voluntary sectors) through the use of a rigorous, standardised assessment and authorisation process. They protect those who lack capacity to consent to arrangements made for their care and/or treatment but who need to be deprived of their liberty in their own best interests to protect them from harm. They also offer the person concerned the right to challenge any decision to deprive them of liberty, a representative to act for them and protect their interests and the right to have their status reviewed and monitored on a regular basis.

The safeguards apply to people aged 18 and above who suffer from a mental disorder (such as dementia or a profound learning disability) and who lack capacity to consent to the arrangements made for their care and / or treatment.

An authorisation is begun by a managing authority, which is either a care home or a hospital. Managing authorities submit a request for an authorisation to a supervisory body, who are Local Authorities for care homes and a Primary Care Trusts (PCTs) for hospitals. Standard authorisation assessments, where no urgent authorisation is in place, must be completed (processed) within 21 days. Standard authorisation assessments where urgent authorisations are in place must be completed within 7 days or, in exceptional circumstances, within 14 days if an extension is granted by the supervisory body.

Urgent authorisations can be issued when a need exists to deprive a person of their liberty immediately to protect them from harm. When an urgent authorisation is used, a standard authorisation must be requested at the same time and must be completed within the time span the urgent authorisation lasts for.

The outcome of a completed assessment is that an authorisation is either granted or not granted, granted meaning that the person will be subject to an authorisation and so be deprived of their liberty. A single authorisation may be granted for any length of time up to a year.

An authorisation may not be granted for a number of different reasons. It could be that since the initial request for an authorisation was made the circumstances surrounding the person have changed, so making the authorisation no longer necessary. Under the legislation there are six reasons why an application may not be granted, which are explained below. Within the legislation specific roles of mental health assessor and best interests assessor exist.

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 best interests assessment must be undertaken by a person who is an Approved Mental Health Professional, or 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.

A minimum of two assessors are required. An assessor can undertake any assessment that they are eligible to carry out but the mental health assessment and best interests assessment cannot be carried out by the same person.

The best interests assessor cannot be a professional who is involved in providing care or in making decisions about the person's care.

If an assessor concludes that the person does not meet the qualifying criteria, for any assessment, then an authorisation cannot be granted. As an application cannot be withdrawn once it has begun, it will be recorded under one of the six categories below and cannot be granted.

Reasons why an authorisation may not be granted are:

1. The age requirement is not met.
   A best interests assessor will assess whether the person is aged 18 or over.
2. Mental health requirement not met.
   A mental health assessor will assess whether the person being deprived of liberty is suffering from a mental disorder within the meaning of the Mental Health Act 1983.
3. Mental capacity requirement not met
   The mental capacity assessor will determine whether the person being deprived of liberty lacks capacity to decide whether to be admitted to, or remain in, a hospital or care home in which they are being, or may be, deprived of liberty.
4. No refusal requirement not met
   The best interests assessor will ensure that the authorisation being requested does not conflict with a valid decision by a donee of lasting power of attorney ('an attorney'), or by a deputy appointed by the Court of Protection, and is not for the purpose of giving any treatment that would conflict with a valid and applicable advance decision made by the relevant person.
5. Eligibility requirement not met.
   This can be carried out by either the mental health assessor or the best interests assessor to determine whether the person is eligible to be deprived of liberty under the MCA DOLS. A person is eligible unless they are subject to a requirement under the Mental Health Act 1983 that conflicts with the authorisation being requested, or object to being to in hospital for the purpose of treatment of a mental disorder, or to being given some or all of the treatment in question, and they meet the criteria for detention under the Mental Health Act 1983.
6. Best interests requirement not met.
   The best interests assessor will establish whether there is a deprivation of liberty and, if there is, whether it is:
   a. In the best interests of the person subject to the authorisation
   b. Necessary in order to prevent them coming to harm
   c. A proportionate response to the likelihood of them suffering harm and the seriousness of that harm.

If a third party (such as a social worker, nurse or care worker) believes someone is deprived of their liberty without authorisation then the concern can be raised with a Managing Authority.

When an authorisation ends, for any reason, the person must cease to be deprived of their liberty immediately.

A series of Standard Forms have been developed for use by both Managing Authorities and Supervisory Bodies in implementing the requirements of the legislation. An additional form has been developed for use by Supervisory Bodies in collating aggregate data from the standard forms for use in routine monitoring, including this publication. Data is collected through the NHS Information Centre for Health and Social Care Omnibus collection system.

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