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Arolygiaeth Gofal a Gwasanaethau Cymdeithasol Cymru
Care and Social Services Inspectorate Wales

Mental Capacity Act 2005
Deprivation of Liberty Safeguards

Monitoring report on the first year of operation
1 April 2009 to 31 March 2010

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Purpose of report

The Mental Capacity Act Deprivation of Liberty Safeguards (the Safeguards) were implemented on 1 April, 2009. They provide a legal framework that protects people living in care homes who are vulnerable because of mental disorder and problems with their mental capacity. Under the Safeguards, people can only be deprived of their liberty when there is no other way to safely care for them and an assessment has been made of their best interests.

This report is the first annual monitoring report from Care and Social Services Inspectorate Wales (CSSIW) for the year 2009/2010. The report identifies the way the Safeguards have been implemented in social care settings and considers the main issues this has raised. It is designed to contribute to the improvement of outcomes for people who have been subject to the Deprivation of Liberty Safeguards. It is also aims to make the Safeguards known to a wider range of people including the families and friends.

Who should read it?

This report is relevant to a wide range of people. This includes service users themselves and their families; senior managers responsible for social services in Wales; chief executives and elected representatives of councils; registered providers and managers of care homes, and advocates especially Independent Mental Capacity Advocates. It aims to inform anyone working in social care, or interested in the way the Safeguards have been used.

How can I find out more?

For more information and further copies of the report please contact:
Care and Social Services Inspectorate Wales, Cathays Park, Cardiff, CF10 3NQ.
Telephone 01443 848450 or e-mail: cssiw@wales.gsi.gov.uk

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1. Introduction

1.1 We all expect to be able to make decisions about our own lives and every day actions constantly and freely within the limits of society and the law. This right only becomes a problem if mental capacity is never achieved or achieved but lost or impaired. The Mental Capacity Act 2005 recognises that these are important matters which concern us all. There are circumstances where inability to make decisions can lead to loss of freedom and choice. If this loss becomes essential to ensure an individual's safety, it must only occur in ways that are controlled, monitored and open to appeal.

1.2 Across Wales, health and social services authorities have worked together to agree how their responsibilities will be met and to provide training to staff at all levels. Managers and staff in supervisory bodies and managing authorities undertook substantial preparation to make sure new processes were in place to use the Safeguards correctly. There was a particular challenge for local authorities and health boards because different parts of their organisations might take one role or the other but not both. Social services have made training available to a range of staff including those in independent care homes through their social care workforce development partnerships.

1.3 The Safeguards require all registered providers operating care homes (managing authorities) to request external assessment when caring for individuals who are mentally disordered and lack the mental capacity to consent to be cared for in ways which deprive them of their liberty. This applies whether the registered care home is run by an independent provider or by a local authority.
The Safeguards do not apply in other locations, such as supported housing or in an individual's own home. However, where mentally disordered people without mental capacity appear to be deprived of their liberty in these circumstances, the Court of Protection must be consulted.

1.4 When acting as supervisory bodies, local authorities are responsible for receiving requests for authorisation from care homes and arranging assessments from properly trained staff. After assessment, if appropriate, they will give the necessary authority for deprivation of liberty. This includes arranging support for individuals deprived of their liberty and keeping matters under review.

1.5 Two linked Codes of Practice give guidance to anyone working with individuals who may lack capacity. One relates to the Mental Capacity Act and the other supplementary code focuses on the Deprivation of Liberty Safeguards in detail. The Code of Practice to the Mental Health Act 1983 is also relevant. The Welsh Assembly Government also issued guidance and model documentation to support the implementation and administration of the Safeguards and their associated regulations. The Inspectorates have referred to these in their reports when appropriate.

2. Monitoring the operation of the Safeguards

2.1 **"The deprivation of a person's liberty is a significant issue**" (MCA Deprivation of Liberty supplementary Code of Practice Chapter 11.)

2.2 The legislation introduced a duty for government to monitor the implementation and operation of the Safeguards. The Welsh Ministers decided that CSSIW (for social care) and Healthcare Inspectorate Wales (HIW) - for healthcare - should monitor the implementation and operation of the Safeguards on their behalf and report annually. This gives Ministers, the National Assembly for Wales and the public information on the way the powers have been used.

2.3 The Code of Practice Chapter 11 sets out the expectations of how monitoring will occur including the requirement for an annual report.

2.4 This happens in two ways:

- through routine inspection of care homes, where inspectors have the opportunity to follow up the care of individuals subject to the Safeguards
- through collecting data and information from the Inspectorates, Supervisory Bodies and Managing Authorities and reporting on it annually.

2.5 Day to Day monitoring of Care Homes

2.6 CSSIW trained staff so that they would be familiar with the requirements made by the Mental Capacity Act 2005 and the additional Deprivation of Liberty Safeguards. This included understanding the responsibilities of managing authorities and supervisory bodies. CSSIW provides inspectors with an inspection checklist to assist Inspectors, which is reviewed regularly.

2.7 As part of day-to-day inspection activities, CSSIW inspects registered care homes and has incorporated monitoring of the managing authorities' responsibilities into routine inspection. When they inspect care homes, inspectors talk to staff about their understanding of the Mental Capacity Act, and explicitly ask about the Deprivation of Liberty Safeguards. If anyone in the care home is lawfully deprived of their liberty though the Safeguards, their file is examined and the individual is seen during the inspection. Inspectors may also see residents who are not subject to an authorisation but appear to be deprived of their liberty. They would discuss this with the managing authority and ensure that appropriate action is taken as a matter of urgency.

2.8 The Annual Monitoring Report

2.9 CSSIW and HIW have developed a similar approach to monitoring the operation of the Safeguards by supervisory bodies and managing authorities to ensure consistency across healthcare and social care services. This is particularly

relevant as in some areas supervisory bodies from both organisations have established joint teams to fulfil their responsibilities. CSSIW and HIW reflect the specific concerns in the social care and health sectors that they have identified and which are reported in the joint executive summary and individual reports.

2.10 Each local authority supervisory body provided information which recorded every DoLS request that was made during the year. This included information on the characteristics of the individual about whom the application was made, information about the Safeguards process, timing and outcome of the application. This has provided the Inspectorate with key statistics about the impact of the Safeguards on individuals and organisations. The local authorities and health boards also completed a qualitative survey designed to capture information on their dual role as supervisory body and managing authority which asked about potential conflicts of interest, training, staff guidance, local policies, etc. CSSIW also sent a similar survey to a small sample (43) of independent care homes asking about their role as managing authority. The sample was chosen from care homes across Wales where a standard DoLS authorisation had been granted since 1st April, 2009.

3. Findings

3.1 The relevant person

3.2 The Safeguards are concerned to empower and protect the individual (called the "relevant person") in the least restrictive way compatible with preventing harm to them. Across Wales, the relevant person most likely to experience a Deprivation of Liberty Safeguard was an older white woman diagnosed with dementia. This reflects the greater numbers of older women in care homes. However, in some parts of Wales this profile varies and is partly dictated by the range of care home facilities in an area. For example, where there are specialist homes for adults under 65 years of age, the average age and mental disorder of the relevant person changes. Three quarters of all referrals were concerned with people receiving social care.

3.3 Supervisory bodies and managing authorities have a duty to inform key people, especially the relevant person and their representative (for example a relative), of their rights and to help them to exercise these rights. Information is required in different formats and appropriate means of communication must be used. The responses to surveys indicate mixed awareness of this important responsibility, with managing authorities showing the most variability. The all-Wales Mental Capacity Network is a group of social services and health managers with responsibility for implementing the Safeguards and they have given this task high priority and produced some clear guidance for staff. However, the information provided from social services does not indicate whether any organisation has tested the effectiveness of their own communication or sought the views of recipients of information. This would demonstrate good practice and provide evidence of a person centred service.

3.4 Managing authorities have to be aware of what the Mental Capacity Act allows if it is necessary to restrict the liberty of someone without mental capacity, even to keep them safe. However, if care home managers decide that a relevant person is being **deprived** of their liberty in the care home and there is no way to do this less restrictively, the Safeguards allow them to give themselves an urgent authorisation, which lasts for up to 7 days. At the same time managing authorities must inform the correct supervisory body. The supervisory body will be the organisation that placed the individual in the home, or the local authority where the individual lived before coming into the care home. The supervisory body then organises six assessments to see whether it should give a standard authorisation which can last up to 12 months.

3.5 In the first year, the majority of requests for a standard authorisation (61 per cent) occurred after managing authorities had identified grounds for an urgent authorisation. This outcome was not anticipated prior to implementation. The DoLS Code of Practice suggests that the "vast majority" of cases should involve standard authorisations, whilst urgent authorisations would be

"exceptional cases." Comparisons can be made with good practice in Adult Protection where good care management and planning should be proactive and highlight potential difficulties for individuals before they become a problem. When assessed, more than half of the situations covered by urgent authorisations did not go on to become a standard authorisation. Discussion with practitioners and managers indicates that best interests assessors considered most of the requests not authorised to be restrictions rather then deprivations of liberty. Improvements to the way this information is collected will mean a more accurate picture in future years. CSSIW will continue to monitor the position.

3.6 In summary, where the urgent deprivations were used, managers may still be unsure of the line between restricting and depriving someone of their liberty. Fewer than half of all requests went on to become standard authorisations, although there was variation across supervisory bodies. This general trend was predicted in the impact assessment completed before the legislation was implemented and partly reflects the difficulty of defining a deprivation of liberty.

3.7 The low number of requests made may be of greater concern. Fewer people have been protected by the Safeguards than forecast. This protection includes the assessment process where independent oversight is applied to an individual's circumstances, whether the outcome leads to authorisation or not. The Inspectorate will continue to review whether the legislation is being used appropriately in future examinations of services. Tables 1a and 1b give the full breakdown of activity and includes both health and social care services.

Table 1a Requests from Managing Authorities to Supervisory Bodies for authorisation of DoLS

	Request for standard authorisation		Request for standard authorisation, where an urgent authorisation is already in place		All requests	
	Number	Per cent	Number	Per cent	Number	Per cent
Local Authority	163	40	249	60	412	75
Health Board	51	38	84	62	135	25
Total	214	39	333	61	547	100

Table 1b Number of requests for authorisation granted and not granted

	Granted		Not granted	
	Number	Per cent	Number	Per cent
Local Authority	177	44	229	56
Health Board	77	57	58	43
Total	254	47	287	53

Number of requests does not always equal the sum of the numbers authorised and not authorised as a small number of requests are in progress or information on the outcome is missing.

3.8 Every request for standard authorisation from a managing authority, whether preceded by urgent authorisation or not triggers the assessment process, comprising six individual assessments. The DoLS supplementary Code of Practice gives a full explanation of the criteria for each assessment. These assessments concern:

- Age
- Mental Capacity
- No refusals
- Mental Health
- Eligibility
- Best Interests

3.9 The six assessments do not have to be completed by different assessors, although there must be a minimum of two assessors. The mental health and the best interests (BI) assessors must be different people.

3.10 The best interests assessor

3.11 Supervisory bodies often instructed BI assessors first to clarify whether a deprivation of liberty had taken place, or was likely to take place. All assessment criteria have to be met before an authorisation can be given, although the BI assessor's recommendation to the supervisory body is paramount. Even if the other five assessments have been satisfied, authorisation cannot be given unless the BI assessor recommends that the deprivation is in the relevant person's best interests

3.12 The BI assessor has a duty to seek the views of a range of people set out in the Code of Practice, including anyone interested in the person's welfare. This involves finding out whether they believe that depriving the relevant person of their liberty is the best way to protect them from harm or to enable them to follow the care plan proposed.

3.13 Once the decision has been made, the BI assessor can recommend conditions for their supervisory body to add to the authorisation and did so in 136 cases. The content of conditions is tailored to individual circumstances and was appropriately varied. When deciding whether conditions should be attached to an authorisation, BI assessors may, for example, make recommendations around contact issues – who may visit and whether they need to be supervised when they see the relevant person. Best Interests assessors in all local authorities recommended conditions, and most authorisations contained conditions. However, there was a range across supervisory bodies. For example, one local authority made one authorisation in the year and attached a condition to it. Another supervisory body made 36 authorisations, 17 of which had conditions. The other local authority with the joint highest number of authorisations (36) attached conditions to all but two of them.

3.14 The BI assessor also advises how long an authorisation should last. Although an authorisation can last up to 12 months, the majority were set for shorter periods ranging from 28 days to six months. There was some variation between social care and health services. In health services most circumstances were shorter term, relating to the period of in-patient care. In social care, more relevant persons were in a permanent placement so the care arrangements might be expected to persist for longer.

3.15 There are other protective aspects in the Safeguards which focus on the welfare of the relevant person. These include:

3.16 Independent Mental Capacity Advocate (IMCA)

3.17 The DoLS Code of Practice specifies when the supervisory body should make approaches to an IMCA, and what the IMCA should do in this context. Chapter 10 of the main Code of Practice sets out details of the Independent Mental Capacity Advocate service more generally. The DoLS Code of Practice states "If there is nobody appropriate to consult, other than people engaged in providing care or treatment in a professional capacity or for remuneration, the managing authority must notify the supervisory body when it submits the application for the deprivation of liberty authorisation. The supervisory body must then instruct an IMCA straight away to represent the person." This is particularly important when an urgent authorisation has been given so that independent representation can be given at an early stage. The IMCA can also apply to the Court of Protection for permission to take the relevant person's case to the Court regarding matters relating to granting or refusing an urgent or standard authorisation. The Code also refers to the process to be followed if differences of opinion occur between an IMCA and an assessor, advising that they should "ideally be resolved while the assessment is still in progress" (Paragraph 3.25.) Neither supervisory bodies nor managing authorities in social care reported any unresolved issues. Comments and information received referred very positively to the IMCA role.

3.18 The Court of Protection

3.19 The Court is referred to extensively in the MCA Code of Practice and the supplementary DoLS Code of Practice. Its role expanded considerably following the introduction of the Mental Capacity Act legislation. One of its key functions relating to the Safeguards is the provision of speedy access to a review of the lawfulness of an individual's deprivation of liberty. Any third party with concerns, including the IMCA, can approach the Court of Protection for advice on the welfare of an individual who lacks capacity. However, the guidance suggests that concerns should, where possible, be resolved informally or through the relevant supervisory body or managing authority's complaints procedure. Local authorities, in their supervisory body role, have recognised that there is some tension for them in deciding whether to resolve disputes within families through the Safeguards or to approach the Court of Protection. Case law issued from the Court of Protection gives important additional guidance to professionals working with individuals who lack capacity.

3.20 The Relevant Person's Representative (RPR)

3.21 If a standard authorisation is given, the Safeguards require a supervisory body to appoint a relevant person's representative (RPR). Their role is to:

- maintain contact with the relevant person, and
- represent and support the relevant person in all matters relating to the deprivation of liberty safeguards. This includes where appropriate triggering a review, using an organisation's complaints procedure on the person's behalf or making an application to the Court of Protection.

3.22 The appointed RPR does not have to agree with the deprivation of liberty. The appointment can be changed to another suitable person during the lifetime of an authorisation.

Table 2 Details of the relevant person's representative in place at the end of an individual's authorisation

	Local Authority		Health Board		Total	
Relevant person's representative	Number	Per cent	Number	Per cent	Number	Per cent
Carer/relative/friend	108	62	54	70	162	65
Other	66	38	23	30	89	35
Total	174	100	77	100	251	100

Due to missing data, totals do not reflect total number of authorisations

3.23 Supervisory bodies in social care have appointed RPRs from a range of suitable people. In general, where RPRs are described as "other," the supervisory bodies appointed "professional" RPRs, for example, from Independent Mental Capacity Advocacy (IMCA) services established through the Mental Capacity Act or other advocacy services. The regulations that support the Safeguards in Wales allow supervisory bodies to make payments to any person acting as an RPR.

3.24 Managing authorities are responsible for monitoring the way RPRs maintain contact with the relevant person, and for notifying the supervisory bodies if there are any concerns. A small number of the managing authorities sampled were aware of this duty and had expectations that contact was recorded in a resident's notes. However, the effectiveness of this approach was rarely being tested in practice and there was little indication of processes to scrutinise these records and pick up concerns. Other managing authorities sampled showed little or no awareness of this duty, and were not recording the RPR input.

3.25 Relatives, carers and friends acting as RPR may require help and support to understand their role and powers. Some supervisory bodies provided a brief explanation through leaflets or by having the Best Interests assessor explain the role during the assessment process. They have the option under section 39D of the Safeguards to appoint an IMCA to support non-professional RPRs. While the data collection did not gather specific information on the appointment of IMCAs in such circumstances, indications from IMCA services are that it has been inconsistently requested, with some local authorities making no requests. IMCA services would welcome the role and there is greater scope to recognise the importance of such support. It is good practice for the supervisory bodies to ensure that RPRs are routinely offered support and assistance.

3.26 Third party requests

3.27 Individuals from outside managing authorities made around two per cent of the requests received. The parties identified as making such requests included advocates, social workers and solicitors acting on behalf of a patient or their family. These third parties were concerned that residents of care homes were being deprived of their liberty and so made requests to the relevant supervisory body to examine the individual's circumstances. There is greater scope for members of the public including relatives and friends to be aware of this role and to understand when it might apply. Both supervisory bodies and managing authorities need to promote understanding more energetically.

3.28 Asking for a review

3.29 Once a standard authorisation has been given, managing authorities can ask for a review of arrangements at any time, although this happened on only 16 occasions. Only four reviews arose from requests by relevant persons or

relevant person's representatives. These low numbers suggest that more could be done to encourage relevant persons and their representatives to ask for reviews. Managing authorities should also consider whether they have used this process sufficiently.

3.30 Inspection by CSSIW inspectors

3.31 Inspectors from CSSIW visited social care settings throughout the year. Where an authorisation was in place, a brief description of the individuals' circumstances and any issues were noted. Inspectors checked to see that any urgent authorisation is always followed by a request to the relevant supervisory body. This is an important part of monitoring.

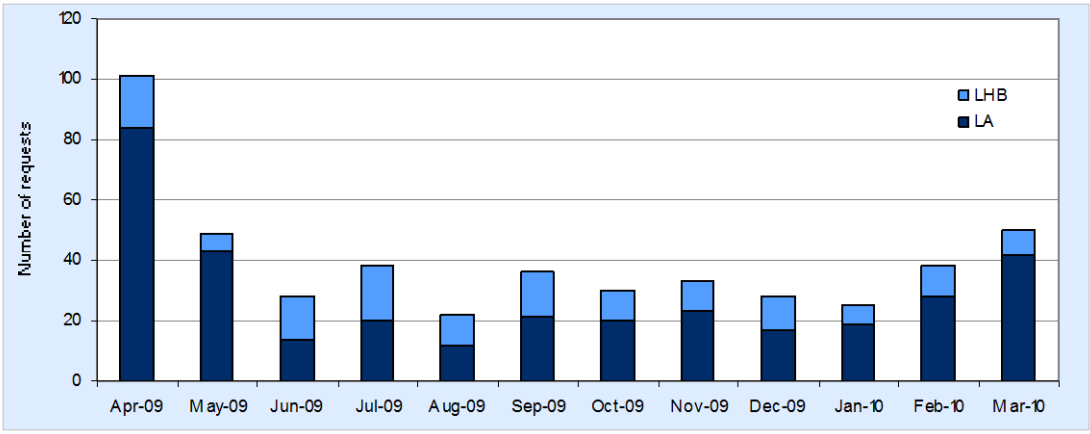
3.32 Because visits are part of routine activity some visits took place before authorisations were put in place, or even while assessments were in progress. Thus consideration of some authorised deprivations of liberty will take place in the second year of its operation (2010/11). Some authorisations had ceased by the time of the inspection although discussions on their impact occurred. In order to ensure that all authorisations are tracked, further work will be undertaken with care homes to require notification direct to CSSIW.

3.33 In the first year of operation fewer than 10 per cent of residential care homes/managing authorities used the Safeguards. CSSIW inspectors did not use the third party referral process although this can be an appropriate option where discussion with managing authorities does not resolve issues. At each inspection of a care home whether an authorisation has occurred or not, inspectors are expected to discuss managers' awareness and understanding of the Mental Capacity Act including the Deprivation of Liberty Safeguards.

3.34 Impact of the legislation

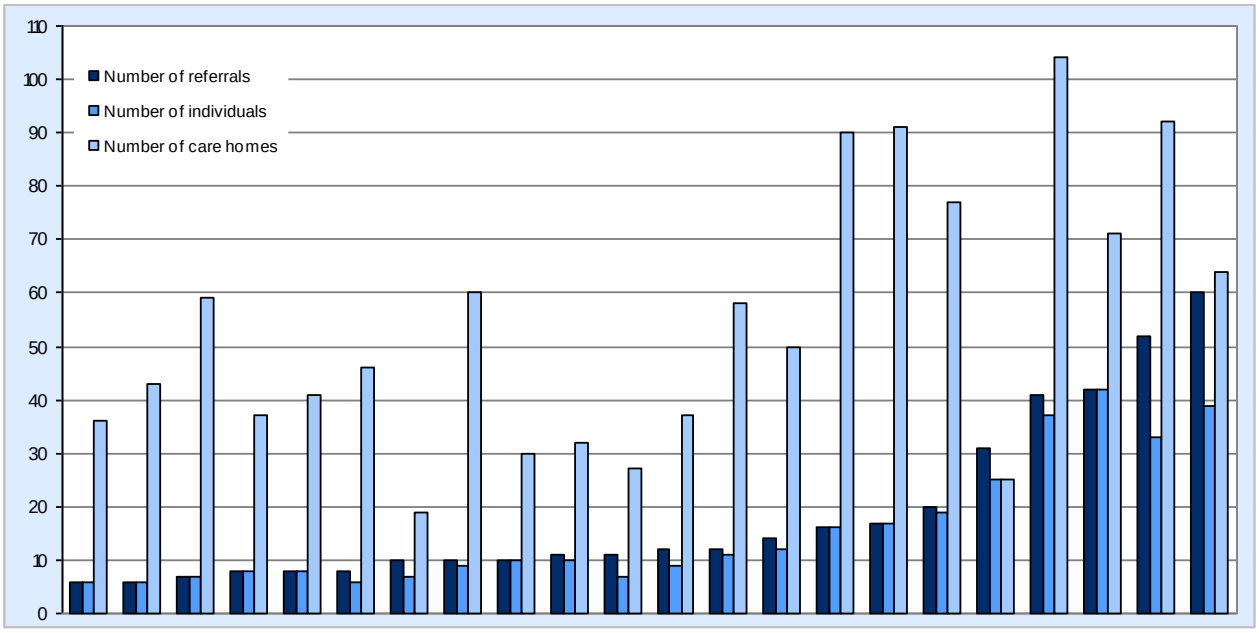
3.35 The most notable outcome in the first year has been variability between each local authority and between local authorities and health boards. Few consistent patterns have emerged. The rate of referrals received from 1st April 2009 fluctuated over the period. Initial levels were higher followed by a decrease over the summer months, before starting to increase once more at the end of the year. This is shown in Chart 1.

Chart 1 Number of referrals to Supervisory Bodies in Wales by month, 2009-10



3.36 The numbers of referrals received by individual local authorities and health boards show considerable variation across Wales. Groups of local authorities located within an area covered by a health board experienced different rates of referrals to each other, with little correlation between population sizes. (See Appendix 3 showing the location of supervisory bodies.) Where joint DoLS teams are in place, they experienced different rates of referrals for each of their partner agencies. The number of care homes within a local authority area did not determine how often the Safeguards were used.

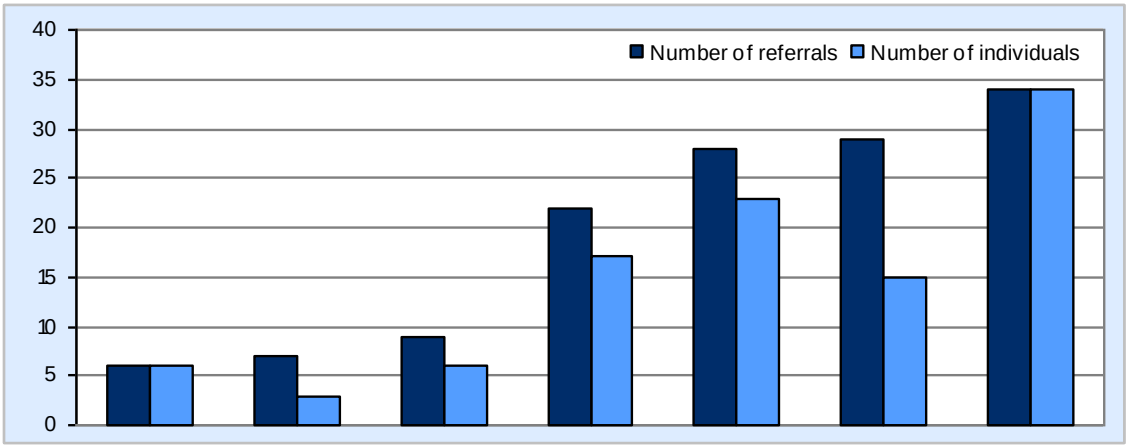
Chart 2 Number of requests for authorisation of deprivation, number of safeguarded residents, and overall number of care homes in each local authority



Number of care homes refers to the number of adult care homes located within the local authority area
Local authority names have been removed to avoid inadvertent disclosure of information

3.37 The number of referrals and the number of individuals affected are different. This is because some individual's circumstances have been considered more than once in the year. Similarly a very small number of individuals will have been subject to the Safeguards in hospital and again when they are discharged to care homes (and vice versa).

Chart 3 Number of requests for authorisation of deprivation and number of safeguarded residents in each health board



3.38 Identifying the supervisory body

3.39 The Safeguards and associated regulation prescribe how this is to be achieved. There are specific responsibilities for the organisations who have arranged placements for individuals in care homes, whether the care homes are within their geographic boundary or not. This ensures that supervisory bodies give appropriate priority and urgency to consider requests for deprivations of liberty and any subsequent review, informed by knowledge of the individual's circumstances. This means, for example, where a local authority places an individual in a care home outside of their boundary, the supervisory body responsibilities are not transferred. This applies no matter how close or distant the care home is from the area where the relevant person previously lived. However, local authorities reported good co-operation where any ambiguity arose, for example by information gathering or starting the BI assessment, even if the responsibility was subsequently transferred to another local authority in Wales or England. Most managing authorities correctly identified the supervisory body.

3.40 Timescales for assessment

3.41 These are prescribed by legislation and are particularly important where urgent authorisations are in place. Where assessment determines there is no deprivation, an urgent authorisation comes to an end immediately.

The supervisory body has five days in which to complete all the required assessments. A managing authority can request an extension to an urgent authorisation of up to seven days, whilst the standard authorisation is being considered. Extensions were only requested on 7 per cent of occasions in social care, nearly all of which the supervisory bodies granted. This reflects well on the efficiency of the supervisory bodies and their assessors.

3.42 Because of the shorter timescales, the high percentage of requests by managing authorities following urgent authorisations has placed a considerable burden on supervisory bodies. They completed the process within the required timescales in 90 per cent (195) of cases. However, there is missing information (over 30 instances) and over 20 instances when more than 14 days were taken to complete the assessments, by which time the urgent authorisation had expired. When standard authorisations are requested, the supervisory body should ensure that all assessments are completed within 21 days of being commissioned. Information reported indicates that this was achieved in the majority (83 per cent) of decisions with some supervisory bodies dealing with requests very quickly. However, there is also missing information in this category. The reported outcomes together with the missing information indicate that all supervisory bodies need to monitor the timescales stringently and to manage poor performance where it applies. Where good performance has been achieved, it is to be commended and should be maintained.

Table 3 Timescales for assessment by local authority supervisory bodies

	Request for standard authorisation		Standard following urgent authorisation already in place		All requests	
Time between request and decision	Number	Per cent	Number	Per cent	Number	Per cent
1-7 days	50	43	160	74	210	64
8-14 days	20	17	35	16	55	17
15-28 days	35	30	20	9	55	17
Over 28 days	5	4	*	*	10	3
Total	115	100	215	100	330	100

Due to missing data, totals do not reflect total number of requests
Figures have been rounded

3.43 Organisational arrangements to support the role of supervisory bodies

3.44 Administration

3.45 The Inspectorate found a variety of arrangements. In some areas consortia were developed between health and social service organisations. This brought advantages to member organisations, such as ensuring a sufficient pool of assessors to work across an area. Such arrangements require robust management and oversight, so that where one organisation leads on the

Safeguards for an area, the other member organisations do not lose sight of their own roles and responsibilities.

3.46 Appointment of assessors

3.47 Supervisory bodies have a responsibility to allocate assessors who meet the requirements laid out in regulations and have suitable skills and knowledge for the relevant person's case. It is important that the staff who undertake assessments have been properly trained and act competently. Those who carry out the best interests assessment have the key role of identifying whether a deprivation exists. If there is a deprivation, they determine whether it is in the person's best interests. Regulations identify who can take on the best interest assessor role, and what their existing qualifications must be. These assessors have needed additional training to undertake the role.

3.48 Selection as an assessor in particular cases was generally based on geographic location and clinical or professional background and knowledge.
The Inspectorates are aware that some areas depend on a small pool of assessors who carry out most of the work. There are advantages and dis-advantages to such arrangements. While this ensures that the BI assessors use their skills regularly and develop expertise, potentially it could mean that assessors do not have sufficiently specialist knowledge to suit the particular circumstances of a resident or patient. For example the same BI assessor can be expected to undertake assessments on young people with schizophrenia, an older person with dementia and someone with a learning disability.

3.49 The table on the next page shows the spread of the professions and the assessments they undertook across supervisory bodies in social and health care.

Table 4

Category of Assessment	Profession of assessors
Age	Supervisory bodies used a mix of Approved Mental Health Professionals[1] (AMHPs), social workers and general and mental health nurses.
Best Interests	The same professional groups were generally selected for their experience in carrying out assessments of care needs.
Capacity	Almost all supervisory bodies made use of Section 12 approved doctors[2], around half also used AMHPs, social workers, nurses or other doctors
Eligibility	All supervisory bodies used Section 12 approved doctors, with just under half also using AMHPs and a few other doctors or mental health nurses. Assessors should also understand eligibility for detention under the Mental Health Act so as to judge which legal framework is the correct one to use.
Mental Health	These assessments were almost always carried out by Section 12 approved doctors
No refusals	Supervisory Bodies used a mix of AMHPs, social workers and nurses

[1] A professional with training in the use of the Mental Health Act approved by a Local Social Services Authority to undertake a number of functions under the Act – can be a social worker, nurse, psychologist or occupational therapist

[2] A doctor who has been approved by the Welsh Ministers, or on their behalf, under the Mental Health Act as having special experience in the diagnosis or treatment of mental disorder. Some medical recommendations and medical evidence to courts under the Mental Health Act can only be made by a doctor who is approved under section 12.

3.50 Training and support for assessors

3.51 Most of the reported assessor training and support activity focused on best interests (BI) assessors. This is not surprising as BI assessors have a wide range of responsibilities to undertake. Their responsibilities include:

- the determination of whether a deprivation is occurring and whether there is a less restrictive alternative,
- deciding what is in the best interests of the relevant person,
- setting conditions,
- recommending RPRs.

3.52 Supervisory bodies are responsible for deciding what this training should be and for assessing and monitoring competency. The majority provided several days training, while others have arranged brief, local training. There is no universal accreditation system as yet in Wales. However, many supervisory bodies have expressed high levels of interest in obtaining accreditation for their BI assessors, and there is a need for further debate in taking this forward. Consistent standards of training which are verified through accreditation would give more robust assurance about the baseline of skills and knowledge that BI assessors bring to the task.

3.53 Most supervisory bodies put support mechanisms in place such as peer support, formal supervision or BI Assessor practice groups. Practice groups discuss issues, cases and receive updates on the emerging case law. As a consequence of the low levels of usage of the Safeguards, some assessors have had few or no opportunities to undertake assessments during the year and have found such updates essential in keeping up their knowledge and confidence levels.

3.54 This does not remove the need for over-sight of the way these skills are exercised or the need for training up-dates. The majority of supervisory bodies described methods of monitoring the performance of their assessors such as checking, evaluating or quality assuring assessments they had undertaken.

3.55 Eligibility for DoLS or the Mental Health Act 1983

3.56 Where the eligibility assessment identifies that the patient falls within the thresholds for application under the Mental Health Act 1983, a Mental Health Act assessment will need to be arranged. Many supervisory bodies use doctors who are approved under Section 12 of the Mental Health Act for the mental health and eligibility assessments under the Safeguards. With their training and skills, they can determine which legal framework applies and then complete the appropriate assessment. Other arrangements include making requests from the appropriate mental health team where necessary.

3.57 There are some areas where both the Mental Health Act and the Deprivation of Liberty Safeguards may be used together, for example, where Section 7 Guardianship under the Mental Health Act has been used to require someone to live in a care home. If the care necessary to keep the individual safe deprives them of their liberty, then guardianship alone may not give sufficient authority. The Safeguards would then need to be considered. Initially, there was some speculation that Section 7, Guardianship under the Mental Health Act might be used more frequently instead of the Safeguards as well as alongside them. However, the statistics published in Wales for the same period do not detail any change with the similar level of usage as the previous year.

4. Findings

4.1 The Deprivation of Liberty Safeguards offer important protection to vulnerable people. Individuals have benefited from the scrutiny best interests assessors bring to aspects of their care whether the requested deprivation is authorised or not. Where they have determined that deprivation is not in the best interests of an individual but that it has been occurring, the supervisory bodies required changes to be made. This has involved the use of other safeguarding mechanisms such as referral to Adult Protection services.

4.2 The number of requests for authorisations has been lower than anticipated. It is important that managing authorities are aware of the Safeguards and draw situations which require authorisation to the attention of the supervisory bodies. Where Safeguards have been authorised the supervisory bodies and managing authorities must maintain the standards of oversight required by the legislation and the Code of Practice guidance in order to ensure real protection.
The variation in usage and level of usage both suggest that better understanding of the Safeguards is needed. Survey information indicates that there are some good internal policies and managers who understand this role, but there is a larger group of managing authorities still coming to terms with these responsibilities.

4.3 Most supervisory bodies provided the required information effectively, but there were exceptions and these have been followed up through the Regional Social Services Link Inspector. The same questions and format will be used again in the second year of monitoring with a small number of agreed improvements. This consistency will help the Inspectorate to look at trends over two years.

4.4 The DoLS Code of Practice proposes that the Court of Protection should be the arbiter for a number of different matters where an authorisation fails to resolve a dispute. On rare occasions managing authorities have been so concerned about the circumstances in which they are asked to provide care to vulnerable people that they have approached the Court of Protection for advice. A small number of local authorities in Wales have submitted cases to the Court of Protection for a decision. Other local authorities have relied on the Safeguards to protect individuals, for example to prevent relatives discharging them from care homes.

4.5 A very small number of third parties made representations to managing authorities and referrals to the supervisory bodies. The public, including family and friends visiting care homes and hospitals, need to know about the Safeguards to realise their potential benefits. (Experience from adult protection services where there are some parallels suggests that family and visitors expressing concerns account for a significant number of referrals.) Supervisory bodies and managing authorities have the responsibility for publicising the Safeguards. Despite some excellent work through the Mental Capacity Act network, this remains an area for development.

4.6 Independent Mental Capacity Advocates have only been asked to support a small percentage of relevant people, and even fewer relevant persons' representatives. Supervisory bodies can ensure that vulnerable people benefit from IMCA's skills more effectively by ensuring that they make referrals to Independent Mental Capacity Advocacy schemes in all appropriate situations.

4.7 A great deal has been achieved in the first year, and some clarity has developed around the benefits the safeguards can bring to individuals. The picture in Wales is similar to that described so far in England. There is evidence of practice development and the achievements made by local authorities as supervisory bodies should be sustained. However, to protect individuals' human rights adequately the Mental Capacity Act and the Deprivation of Liberty Safeguards must be well known, well understood and embedded into social care practice.

Appendix 1

What are the Deprivation of Liberty Safeguards and why were they introduced?

These Safeguards are an integral part of the Mental Capacity Act 2005 although they were introduced as an amendment under the Mental Health Act in 2007and designed to remedy incompatibility between English law and the European Convention on Human Rights. The Mental Capacity Act has to be understood before the Deprivation of Liberty Safeguards can be considered.

The Mental Capacity Act provides a statutory framework to recognise, empower and protect vulnerable people who are not able to make their own decisions without assistance. The Mental Capacity Act makes clear how people may be supported to make decisions and how decisions may be taken on behalf of people who lack capacity permanently. It enables people who have capacity to plan ahead for a time when they may lose capacity.

The Mental Capacity Act is based on five principles:

- A presumption of capacity – every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise;
- The right for individuals to be supported to make their own decisions – people must be given all appropriate help before anyone concludes that they cannot make their own decisions;
- That individuals must retain the right to make what might be seen as eccentric or unwise decisions;
- Best interests – anything done for or on behalf of people without capacity must be in their best interests; and
- Least restrictive intervention – anything done for or on behalf of people without capacity should be the least restrictive of their basic rights and freedoms.

These principles also underpin the Deprivation of Liberty Safeguards (DoLS).
The Safeguards provide a legal framework which prevents arbitrary decision-making. They can only apply where an individual has a mental disorder including learning disabilities and lacks the capacity to consent to the arrangements made for their care or treatment. To be lawful, the circumstances of this care or treatment must amount to a deprivation of their liberty within a care home or hospital and, following assessment, must be in their best interests. It must also be a proportionate response to the likelihood of the relevant person suffering harm and the seriousness of that harm. Full consideration has to be given to other less restrictive alternatives before a deprivation can be authorised.

The safeguards place duties on a hospital or care home, known as the managing authority in this legislation. When the managing authority identifies that it is, or soon will be, depriving a resident or in-patient who lacks capacity of their liberty, they must apply

for authorisation of the deprivation. This may be given by the relevant supervisory body (health boards and local authorities) following assessment against six criteria which are defined fully in legislation and the DoLS Code of Practice. (See Appendix 2 Summary of Key terms.)

An assessment has to be made against each criterion and must take place within specific timescales. Supervisory bodies should ensure that assessments for standard authorisation are completed within 21 days. Where a managing authority identifies that a deprivation of liberty is already occurring, it may grant itself an Urgent Authorisation which can last for 7 days. The managing authority must in all circumstances apply for a standard authorisation at the same time from the relevant supervisory body. Standard authorisation assessments must take place within 7 days, or in exceptional circumstances, 14 days if an extension is applied for by the Managing Authority and granted by the Supervisory Body.

All assessments can be undertaken by the same assessor except the Mental Health assessment and the Best Interests assessment which must be made by two different assessors. (Their specific qualifications and training are set out in the Welsh regulations. Neither can be involved in providing care or in making other decisions about the person's care.) The Best Interests assessor will establish whether the least restrictive alternatives have been considered and whether there is or should be a deprivation of liberty. If so, the BIA will consider whether it is:

- in the best interests of the person
- necessary to prevent them coming to harm
- a proportionate response to the likelihood of them suffering harm and the seriousness of that harm

If all six assessments apply, then the supervisory body must issue a standard authorisation to the managing authority. It can place conditions on this and limit its length. No authorisation can last more than 12 months, and cannot be extended. If required fresh assessments and consultation must occur. When an authorisation ends, for any reason, the person must cease to be deprived of their liberty immediately. However, a new authorisation can be made to run consecutively. If assessors decide that any of the six criteria do not apply, then the authorisation cannot be granted.

Appendix 2

Summary of key terms used in the DoLS Annual Report

The table below is not a full index or glossary. Instead, it is a list of key terms used in this Annual Report. Where necessary it may expand on particularly important tasks carried out by significant people.

Advocacy	Independent help and support with understanding issues and putting forward a person's own views, feelings and ideas.
Approved mental health professional	A social worker or other professional approved by a social services authority to carry out a variety of functions under the Mental Health Act, 1983. Previously this role was called an Approved Social Worker (ASW).
Assessment for the purpose of the deprivation of liberty safeguards	All six assessments be positive for an authorisation to be granted.
Age assessment	An assessment of whether the relevant person has reached age 18.
Best interests assessment	An assessment of whether deprivation of liberty is in a detained person's best interests, is necessary to prevent harm to the person and is a proportionate response to the likelihood and seriousness of that harm. This must be decided by a Best Interests assessor.
Eligibility assessment	An assessment of whether or not a person is rendered ineligible for a standard deprivation of liberty authorisation because the authorisation would conflict with requirements that are, or could be, placed on the person under the Mental Health Act 1983.
Mental capacity assessment	An assessment of whether or not a person lacks capacity in relation to the question of whether or not they should be accommodated in the relevant hospital or care hone for the purpose of being given care or treatment.
Mental health assessment	An assessment of whether or not a person has a mental disorder. This must be decided by a medical practitioner.
No refusals assessment	An assessment of whether there is any other existing authority for decision-making for the individual (relevant person) that would prevent the giving of a standard deprivation of liberty authorisation. This might include any valid advance decision, or valid decision by a deputy or donee appointed under a Lasting Power of Attorney.

Assessor	A person who carries out a deprivation of liberty safeguards assessment.
Capacity	Short for mental capacity. The ability to make a decision about a particular matter at the time the decision needs to be made. A legal definition is contained in section 2 of the Mental Capacity Act 2005.
Care Home	A care facility registered under the Care Standards Act 2000
CSSIW	Care and Social Services Inspectorate Wales is responsible for regulating, inspecting and reviewing social care services. It makes making professional assessments and judgements about social care, early years and social services and encourages improvement by raising standards, improving quality and promoting best practice. It carries out its functions on behalf of Welsh Ministers.
Carer	Someone who provides unpaid care by looking after a friend or neighbour who needs support because of sickness, age or disability. In this report the term carer does not mean a paid care worker.
Conditions	Requirements that a supervisory body may impose when giving a standard deprivation of liberty authorisation, after taking account of any recommendations made by the best interests assessor.
Consent	Agreeing to a course of action – specifically in this report to a care plan or treatment regime. For consent to be legally valid, the person giving it must have the capacity to take the decision, have been given sufficient information to make the decision, and not have been under any duress or inappropriate pressure.
Court of Protection	The specialist court for all issues relating to people who lack capacity to make specific decisions.
Deprivation of Liberty	Deprivation of liberty is a term used in the European Convention on Human Rights about circumstances when a person's freedom is taken away. Its meaning in practice is being defined through case law.
Deprivation of Liberty Safeguards	The framework of safeguards under the Mental Capacity Act 2005 for people who need to be deprived of their liberty in a hospital or care home in their best interests for care or treatment and who lack the capacity to consent to the arrangements made for their care or treatment.
Deprivation of liberty safeguards assessment	Any one of the six assessments that need to be undertaken as part of the standard deprivation of liberty authorisation process.

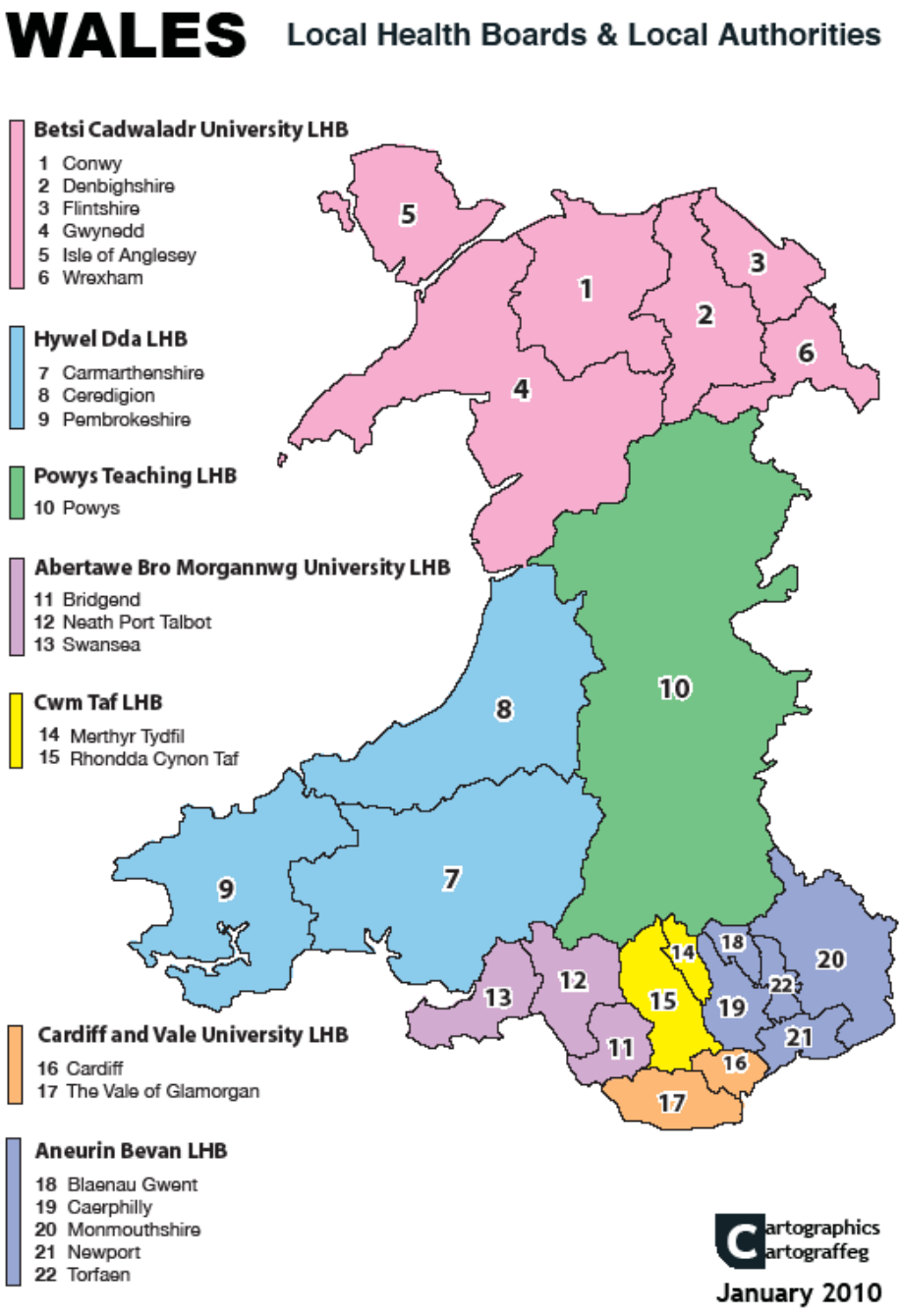
Guardianship under the Mental Health Act 1983	The appointment of a guardian to help and supervise patients in the community for their own welfare or to protect other people. The guardian may be either a local authority or a private individual approved by the local authority.
HIW	Healthcare Inspectorate Wales is the leading regulator of all healthcare in Wales. Its purpose is to provide independent and objective assurance on the quality, safety and effectiveness of health services, making recommendations to healthcare organisations to promote improvements. It carries out its functions on behalf of Welsh Ministers.
Independent Hospital	As defined by the Care Standards Act 2000 – a hospital which is not a health service hospital is an independent hospital, the main purpose of which is to provide medical or psychiatric treatment for illness or mental disorder or palliative care or any other establishment, not being a health service hospital as defined, in which treatment or nursing (or both) are provided for persons liable to be detained under the Mental Health Act 1983
Independent Mental Capacity Advocate (IMCA)	Someone who provides support and representation for a person who lacks capacity to make specific decisions, where the person has no-one else to support them. The IMCA service was established by the Mental Capacity Act 2005 whose functions are defined within it.
Lasting Power of Attorney	A Power of Attorney created under the Mental Capacity Act 2005 where someone appoints an attorney (donee) or attorneys, to make decisions about their personal welfare, including health care, and/or deal with their property and affairs.
Local Authority	In the deprivation of liberties context, the local council responsible for social services in any particular area of the country. Social services fulfil the supervisory body function for social care services.
Local Health Board (LHB)	Local Health Boards fulfil the supervisory body function for health care services and work alongside their respective local authorities in planning long-term strategies for dealing with issues of health and well-being.
Managing authority	The person or body with management responsibility for the hospital or care home in which a person is, or may become, deprived of their liberty. They are accountable for the direct care given in that setting.

Maximum authorisation period	The maximum period for which a supervisory body may give a standard deprivation of liberty authorisation, which must not exceed the period recommended by the best interests assessor, and which cannot be for more than 12 months.
Mental Disorder	Any disorder or disability of the mind, apart from dependence on alcohol or drugs. This includes all learning disabilities.
Mental Health Act 1983	Legislation mainly about the compulsory care and treatment of patients with mental health problems. It covers detention in hospital for mental health treatment, supervised community treatment and guardianship.
Qualifying requirement	Any one of the six qualifying requirements(age, mental health, mental capacity, best interests, eligibility and no refusals) that need to be assessed and met in order for a standard deprivation of liberty authorisation to be given.
Relevant hospital or care home	The hospital or care home in which the person is, or may become deprived of their liberty.
Relevant person	A person who is, or may become, deprived of their liberty in a hospital or care home.
Relevant person's representative	A person, independent of the relevant hospital or care home, appointed to maintain contact with the relevant person, and to represent and support the relevant person in all matters relating to the operation of the deprivation of liberty safeguards.
Restriction of liberty	An act imposed on a person that is not of such a degree or intensity as to amount to a deprivation of liberty.
Review	A formal, fresh look at a relevant person's situation when there has been, or may have been, a change of circumstances that may necessitate an amendment to, or termination of, a standard deprivation of liberty authorisation.
Standard authorisation	An authorisation given by a supervisory body, after completion of the statutory assessment process, giving lawful authority to deprive a relevant person of their liberty in the relevant hospital or care home.
Supervisory body	A local authority social services or a local health board that is responsible for considering a deprivation of liberty request received from a managing authority, commissioning the statutory assessments and, where all the assessments agree, authorising deprivation of liberty. They must also respond to concerns from third parties, who believe that a person is being deprived of their liberty without authorisation.

Third party requests	If anyone (in addition to the relevant person themselves) is concerned a person is being deprived of their liberty without authorisation they should draw this to the attention of the managing authority. This term applies to anyone other than the relevant person themselves. The Code of Practice sets out guidance for addressing matters with the managing authority and if matters are not quickly resolved, with the relevant supervisory body..
Unauthorised deprivation of liberty	A situation in which a person is deprived of their liberty in a hospital or care home without the deprivation being authorised by either a standard or urgent deprivation of liberty authorisation.
Urgent authorisation	An authorisation given by a managing authority for a maximum of seven days, which subsequently may be extended by a maximum of a further seven days by a supervisory body, that gives the managing authority lawful authority to deprive a person of their liberty in a hospital or care home while the standard deprivation of liberty authorisation process is undertaken.

Appendix 3

Map of Wales showing location of Supervisory Bodies (local authority social services and health boards)



Appendix 4

List of relevant guidance and information

A number of documents were published to support understanding of the Safeguards:

Mental Capacity Act, 2005 – Code of Practice
Issued by the Lord Chancellor on 23rd April 2007 in accordance with sections 42 and 43 of the Act.

Deprivation of Liberty Safeguards – Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice, Laid before Parliament by the Ministry of Justice

Mental Health Act 1983 Code of Practice for Wales
Issued by the Welsh Assembly Government 2008

Guidance to Supervisory Bodies working within the Mental Capacity Act Deprivation of Liberty Safeguards
Issued by the Welsh Assembly Government, February 2009

Guidance for Managing Authorities working within the Mental Capacity Act Deprivation of Liberty Safeguards
Issued by the Welsh Assembly Government, February 2009

Standard forms and letters for the Mental Capacity Act Deprivation of Liberty Safeguards
Issued by the Welsh Assembly Government, February 2009

Mental Capacity (Deprivation of Liberty: Appointment of Relevant person's Representative)(Wales) Regulations 2009

Mental Capacity (Deprivation of Liberty: Assessments, Standard Authorisations and Disputes about residence) (Wales) Regulations 2009

Other documents which were considered when compiling the Annual Report:

Impact Assessment of the Mental Capacity (Deprivation of Liberty: Monitoring and Reporting; and Assessments)
Department of Health

The Mental Capacity Act 2005, Deprivation of Safeguards – the early picture
Issued by the Department of Health April 2010 *(www.doh.gov.uk)*