Mental Capacity Act 2005
Deprivation of Liberty Safeguards

Policy Document

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# MCA Deprivation of Liberty Safeguards Policy

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Deprivation of Liberty Safeguards

1. Introduction

1.1 This Policy document provides guidance about the Deprivation of Liberty Safeguards (DoLS), whilst also providing details regarding how these safeguards link into the Mental Capacity Act 2005. It provides information about the specific roles in these processes, their responsibilities and how they should be applied when a Service User is situated in, or is due to be situated within a care home or hospital in Norfolk in a way that is or may be deemed to be a deprivation of liberty.

1.2 The term “Deprivation of Liberty” is used to describe the care or treatment that involves restrictions being placed upon a Service User who lacks the mental capacity to consent to particular treatment or care recognised by others as being in their “best interests” or which will protect them from harm.

The Deprivation of Liberty Safeguards do not apply to people, whilst they are being detained in hospital under the Mental Health Act 1983.

1.3 This document has been produced for staff in Norfolk working within:

- Norfolk County Council Adult Social Services
- Care homes registered under the Care Standards Act 2000
- Acute & Community Hospitals – including hospices (this does not apply to the Hospice at Home service)
- Mental Health Trusts
- Norfolk Learning Difficulties Partnership

working with Service Users who lack the capacity to consent to care or treatment in circumstances that might be considered a “deprivation of liberty”.

1.4 This document is also for staff working within these professional roles outside Norfolk, where the Service User (who lacks the capacity to consent to care or treatment in circumstances that might be considered a “deprivation of liberty”) is likely to be moving to or returning to Norfolk or for whom Norfolk County Council remains the responsible authority under Ordinary Residence arrangements.

1.5 Staff will need to be familiar with and apply the principles of confidentiality within their roles in the DoLS process.

1.6 Staff will need to be familiar with and apply the principles of Adult Safeguarding whilst working in accordance with the DoLS process. The guidance can be found by following the attached link: [http://www.norfolk.gov.uk/safeguardingadults](http://www.norfolk.gov.uk/safeguardingadults)

1.7 Staff will need to be familiar with the principles regarding access to records within their roles in the DoLS process.
1.8 To ensure consistency the term “Relevant Person” is used throughout this guidance document wherever possible, as a term of reference for the Service User. In addition the term “Managing Authority” is used wherever possible to refer to a care home or hospital and “Supervisory Body” is used wherever possible to refer to the Local Authority (Norfolk County Council).

1.9 This Guidance should be read in conjunction with both, the Mental Capacity Act 2005 Code of Practice and also the Deprivation of Liberty Safeguards Code of Practice 2007 as well as any superseding or other relevant legislation.

A link to both the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards Codes of Practice:


2. Identifying a Deprivation of Liberty

2.1 Whenever a care home or hospital identifies that a person who lacks capacity is being, or risks being, deprived of their liberty, they must apply to the Supervisory Body for an Authorisation to deprive the Relevant Person of their liberty if it is within the scope of the Deprivation of Liberty Safeguards. Applications can be made using Norfolk’s e-DOLS system

There are two types of Authorisation (1) Standard and (2) Urgent:

**Standard Authorisation** - A Managing Authority must request a Standard Authorisation when it appears likely that, at some time during the next 28 days, someone will be accommodated in its care home or hospital in circumstances that amount to a deprivation of liberty within the meaning of Article 5 of the European Convention on Human Rights.

**Urgent Authorisation** – Where it is not possible, and the Managing Authority believes it is necessary to deprive someone of their liberty in their “best interests” before the standard authorisation process can be completed, the Managing Authority must itself give an Urgent Authorisation and then obtain a Standard Authorisation within seven calendar days. An urgent authorisation can be for a maximum of 7 days but may be extended by the Supervisory Body for up to a further 7 days in exceptional circumstances.

2.2 Where the deprivation of liberty safeguards are applied to a person, the Supervisory Body will be the local authority for the area in which the person is ordinarily resident. In the event that the Relevant Person is not ordinarily resident in the area of any local authority, the Supervisory Body will be the local authority for the area in which the care home or hospital is situated.
To work out the place of ordinary residence, the usual mechanisms under the Care Act 2014 apply – see: [https://www.gov.uk/government/collections/ordinary-residence-pages](https://www.gov.uk/government/collections/ordinary-residence-pages)

2.3 The Deprivation of Liberty Safeguards are solely about ensuring there are appropriate safeguards in place when it is deemed a person who lacks the capacity to decide the matter for themselves needs to receive care or treatment, deemed to be in their best interests in care home or hospital, in circumstances that will deprive them of their liberty.

The Safeguards **do not** determine whether a Service User who lacks the capacity to consent to particular treatment or care for themselves, should receive care or treatment nor do they provide any new power to take and convey people to hospitals or care homes.

2.4 The Supreme Court Judgment ([P v Chester and Cheshire West and P&Q v Surrey County Council](https://www.gov.uk/government/collections/ordinary-residence-pages)) was handed down on 19th March 2014 and established an ‘acid test’ for deciding whether or not someone was being deprived of their liberty. The court held that the factors for deciding when a person lacking capacity is being deprived of their liberty are that:

- The person is subject to continuous supervision and control; and
- The person is not free to leave; and
- The person lacks capacity to consent to their care arrangements.

The [Code of Practice on the Deprivation of Liberty Safeguards](https://www.gov.uk/government/collections/ordinary-residence-pages) contains further details, but, whether someone is being deprived of their liberty or not will be a matter of judgment and interpretation by care staff and ultimately by the courts.

2.5 Anyone with a concern, e.g. a family member, can apply to the Supervisory Body to trigger an assessment to determine whether a person is deprived of liberty, if they have asked the care home or hospital to apply for authorisation but it has not been done. This would lead to the full assessment process if the initial finding is that the person is deprived of their liberty.

3. **Supervisory Body Actions on Receipt of a Request**

3.1 When a Supervisory Body receives a request for a **Standard Authorisation** of deprivation of liberty they must obtain six assessments. These assessments must be completed within 21 days of the Supervisory Body receiving the request for the authorisation.

However, if an urgent authorisation has been given by the care home or hospital, the assessments must be completed before the expiry of the urgent authorisation (within seven days of receipt by the Supervisory Body, unless an extension to the urgent authorisation is granted).

The assessments are:
1. **Age Assessment** – to clarify that the person is 18 or over.

2. **No Refusals Assessment** – to clarify that the Authorisation would not conflict with a valid decision by:
   - a donee of a Lasting Power of Attorney (an Attorney) for Health and Welfare, or
   - a deputy appointed for the person by the Court of Protection (a Deputy) for Health and Welfare and is not for the purpose of giving treatment that would conflict with a valid and applicable advance decision to refuse treatment made by the person, when they had the capacity to make the advance decision.

3. **Mental Capacity Assessment** – to clarify whether the person lacks the mental capacity to decide whether to be admitted to, or remain in, the hospital or care home.

4. **Mental Health Assessment** – to clarify whether the person is suffering from a mental disorder within the meaning of the Mental Health Act 1983.

5. **Eligibility Assessment** – to clarify if the person is eligible. A person is eligible unless they are:
   a. Detained under the Mental Health Act 1983
   b. Subject to a requirement under the Mental Health Act 1983 that conflicts with the authorisation sought e.g. subject to guardianship requiring them to live somewhere else.
   c. Subject to powers of recall under the Mental Health Act 1983

   Or unless the application is to enable mental health treatment in hospital and they object to being in hospital or to the treatment in question. In deciding whether a person objects, their past and present behaviour, wishes, feelings, views, beliefs, and values should be considered where relevant.

6. **Best Interests Assessment** – to clarify whether the proposed course of action would constitute a deprivation of liberty and it is:
   (i) In the best interests of the person to be subject to the authorisation, and
   (ii) Necessary in order to prevent harm to them, and
   (iii) A proportionate response to the likelihood of suffering harm and the seriousness of that harm

3.2 In line with the provisions of the Mental Capacity Act 2005, anyone who does not have family or friends who can be consulted will have an Independent Mental Capacity
Advocate (IMCA) instructed to support and represent them during the assessment process.

4. **Standard Authorisation**

4.1 If all the assessments conclude the relevant person meets the criteria for an authorisation to be issued, the Supervisory Body must grant the request for a Standard Authorisation of deprivation of liberty. However, the Supervisory Body may attach restrictions / conditions to the Authorisation, and may reduce the time period of a standard authorisation but **must not** exceed the length of time recommended by the Best Interests Assessor.

The length of time a Standard Authorisation may remain in force is a period not exceeding 12 months.

4.2 Authorisation must be in writing and include the purpose of the deprivation of liberty, the time period, any conditions attached and the reasons that each of the qualifying conditions are met.

4.3 The Supervisory Body must give a copy of the authorisation to the Managing Authority, the relevant person, any IMCA instructed and all interested persons consulted by the best interests assessor.

5. **If an Authorisation is not Granted**

5.1 If any of the assessments conclude the Relevant Person does not meet the criteria for an Authorisation to be issued, the Supervisory Body must refuse the request for authorisation. If this happens, the Supervisory Body must inform the Managing Authority, the Relevant Person, any IMCA instructed and all persons consulted by the Best Interests Assessor of the decision and the reasons for it. The Managing Authority must then notify the Care Quality Commission that they have applied for a Standard Authorisation and this has not been granted.

5.2 Where it is decided that it is not in the Relevant Person’s “best interests” to be deprived of their liberty in a particular care home or hospital, steps will need to be taken by the care home or the hospital to find an alternative way of lawfully providing the care they require and they should work closely with the Best Interests Assessor to ensure this is completed. If necessary a safeguarding referral will be raised.

5.3 If the authorisation is for detention to enable life sustaining treatment or treatment believed necessary to prevent a serious deterioration in the person’s condition, and there is a question about whether it may be lawfully granted, practitioners will need to consider using Sections 5 and 6 of the Mental Capacity Act 2005 or the common law Doctrine of Necessity whilst a decision is sought from the Court of Protection.
6. **Duration of Authorisation**

6.1 The duration of any authorisation will be assessed on a case-by-case basis, taking account of the individual’s circumstances. If the Best Interests Assessor concludes that a deprivation of liberty is necessary in a person’s best interests to protect them from harm, they will be required to recommend the time period of the authorisation, taking account of the possibility of circumstances changing. The maximum period for an authorisation would be 12 months but it is expected that authorisations would be for shorter periods in some cases.

7. **Appointment of Relevant Person’s Representative**

7.1 If the Best Interests Assessor concludes that a deprivation of liberty is necessary in a person’s “best interests” to protect them from harm, they are required to recommend who will be the best person to be appointed as the Relevant Person’s Representative in order to represent the person’s interests.

7.2 The Relevant Person may choose their own representative, if they have the capacity to do so. Alternatively, if there is an Attorney or Deputy appointed with the appropriate authority, they may select either of those persons to be the representative.

7.3 Should the Relevant Person be unable to choose their own representative or an attorney / donee or deputy with the appropriate authority is unavailable, then the Best Interests Assessor will consider whether there is someone among those they have consulted who would be suitable.

7.4 The role of the Relevant Person’s Representative is to keep in touch with the person, to support them in all matters concerning the Authorisation and to request a review or to make an application to the Court of Protection if necessary. For details regarding who can undertake the role of the Relevant Person’s Representative refer to the Office of the Public Guardian publication Deprivation of Liberty Safeguards – A Guide for Relevant Person’s Representatives. A link to their website and the Department of Health website is listed below: [http://www.publicguardian.gov.uk/index.htm](http://www.publicguardian.gov.uk/index.htm)

7.5 If there is no one available among friends or family, then the Supervisory Body will appoint a person, who may be paid, to act as the representative for the duration of the authorisation.

8. **Responsibilities of Managing Authorities on Receipt of a Standard Authorisation**

8.1 Managing Authorities have a duty to:

- Take all practical steps to ensure that the Relevant Person and their representative understand what the authorisation means for them and how they can apply to the Court of Protection or request a review
• Ensure that any conditions attached to the authorisation are met; and

• Monitor the individual’s circumstances as any change may require them to request that the authorisation is reviewed.

• Notify the Care Quality Commission of the outcome of the request for the Standard Authorisation

8.2 The Managing Authority can apply for a further Authorisation when the Authorisation expires in which case the procedures laid out for a Standard Authorisation would be repeated. It is good practice for Managing Authorities to reassess the Relevant Person 28 days prior to the Authorisation expiring and reapply for a Standard Authorisation if appropriate. Applications can be made using Norfolk’s e-DOLS system

9. Reviews of Standard Authorisations

9.1 A review may be carried out while an Authorisation is in place for the following reasons:

• The Managing Authority requests a review because the person’s circumstances have changed.

• The Relevant Person or their representative requests a review.

9.2 The Supervisory Body must conduct a review if asked to do so as above. Assessments would be carried out for any of the criteria for authorisation affected by any change of circumstances. The outcome of the review may be to terminate the Authorisation, vary the conditions attached or change the reason recorded so that the Relevant Person meets the criteria for authorisation. The Managing Authority, the Relevant Person and their representative must be informed of the outcome of a review. A request for a review may be made using Norfolk’s e-DOLS system

9.3 The Relevant Person, or the person appointed as their representative, or an Attorney or Deputy, can at any time request that an Authorisation be reviewed by the Supervisory Body. Those persons also have the right to make an application to the Court of Protection to challenge the decision to authorise deprivation of liberty at any time.

9.4 Where an IMCA is instructed, they can provide support with a review or with an application to the Court of Protection. Any other person may apply to the Court of Protection for permission to challenge a decision to deprive a person of their liberty. Legal Aid is available for challenges by the person deprived of liberty or their representative to the Court of Protection

10. What is a Deprivation of Liberty?

10.1 The Supreme Court Judgment (P v Chester and Cheshire West and P&Q v Surrey County Council) was handed down on 19th March 2014 and established an ‘acid test’ for deciding whether or not someone was being deprived of their liberty. The court held that the factors for deciding when a person lacking capacity is being deprived of their liberty are that:
The person is subject to continuous supervision and control; and
The person is not free to leave; and
The person lacks capacity to consent to their care arrangements.

The Code of Practice on the Deprivation of Liberty Safeguards contains further details, but whether someone is being deprived of their liberty or not will be a matter of judgment and interpretation by care staff and ultimately by the courts.

10.2 The European Court of Human Rights (ECHR) has made it clear that the question of whether someone has been deprived of liberty depends on the particular circumstances of the particular case. Specifically, the ECHR said in its October 2004 judgement in HL v UK:

“to determine whether there has been a deprivation of liberty, the starting point must be the specific situation of the individual concerned and account must be taken of a whole range of factors arising in a particular case such as the type, duration, effects and manner of implementation of the measure in question. The distinction between a deprivation of, and restriction upon, liberty is merely one of degree or intensity and not one of nature or substance.”

10.3 Although the guidance within the DoLS Code of Practice details findings from past decisions of the courts, which can be useful when attempting to evaluate whether a deprivation of liberty is occurring, each individual case must be assessed on its own circumstances.

10.4 Section 6 (4) of the Mental Capacity Act 2005 (Paragraph 6.40 of the MCA Code of Practice) states that someone is using restraint if they:

• Use force – or threaten to use force – to make someone do something that they are resisting, or
• Restrict a person’s freedom of movement, whether they are resisting or not.

10.5 Paragraphs 6.40 to 6.48 of the Mental Capacity Act Code of Practice contain guidance about the appropriate use of restraint. Restraint is appropriate when it is used to prevent harm to the person who lacks capacity and it is a proportionate response to the likelihood and seriousness of harm. Appropriate use of restraint falls short of deprivation of liberty. The Commission for Social Care Inspection (CSCI) publication “Rights, Risks and Restraint” gives guidance about restraint in this context.

10.6 Preventing a person from leaving a care home or hospital unaccompanied because there is a risk, for example that they would try to cross a road in a dangerous way, is likely to be seen as proportionate restraint to prevent the person from coming to harm. That would be unlikely, in its self, to constitute a deprivation of liberty. Similarly, locking a door to guard against immediate harm is unlikely, in itself to amount to a deprivation of liberty; however if they were also under continuous supervision and control whilst they were in the care home or hospital, it is likely that the ‘acid test’ established by the Supreme Court would be met and the person may be being deprived of their liberty.

10.7 The ECHR has also indicated that the duration of any restrictions is a relevant factor when considering whether or not a person is deprived of their liberty. This suggests
that actions that are immediately necessary to prevent harm, may not, in themselves, constitute a deprivation of liberty.

10.8 However, where the restriction or restraint is frequent, cumulative and ongoing, or if there are any other factors present, care providers should consider whether this has gone beyond permissible restraint, as defined within The Mental Capacity Act 2005. If so, they must apply for an Authorisation under the Deprivation of Liberty Safeguards (as explained earlier in this guidance document) or change their care provision to reduce the level of restraint to a less restrictive option.

10.9 In order to come within the scope of a deprivation of liberty authorisation, a person must be detained in care home or hospital, for the purpose of being given care or treatment in circumstances that amount to a deprivation of liberty. As part of the care planning process, consideration should be given to the potential of a deprivation of liberty arising in instances of respite care and the taking of the necessary steps to prevent the deprivation arising.

11. Key Points Regarding DoLS

11.1 People who suffer from a disorder or disability of the mind (such as dementia or a profound learning disability) and who lack the mental capacity to consent to the care or treatment they need, should be cared for in a way that does not limit their rights or freedom of action. In some cases members of this vulnerable group need to be deprived of their liberty for treatment or care because this is necessary in their best interests to protect them from harm.

11.2 The aim of the DoLS is to provide legal protection for those vulnerable people who are deprived of their liberty otherwise than under the Mental Health Act 1983, to prevent arbitrary decisions to deprive a person of liberty and to give rights to challenge deprivation of liberty authorisations.

11.3 The safeguards apply to people who lack capacity to consent to treatment, and who have a disorder of the mind.

11.4 The five statutory principles underpinning the Mental Capacity Act 2005 will apply to the operation of these safeguards, principally the requirement to act in the best interests of the person lacking capacity to consent to the care or treatment and to locate the less restrictive option.

12. Who is Covered by DoLS?

12.1 The Deprivation of Liberty Safeguards cover people in hospital, and in care homes registered under the Care Standards Act 2000, whether placed under public or private arrangements.

The safeguards apply to people aged 18 and over whom:

(i) Suffer from a disorder or disability of mind, and
(ii) Lack the capacity to give consent to the arrangements made for their care or treatment, and

(iii) For whom such care (in circumstances that amount to a deprivation of liberty within the meaning of Article 5 of the European Convention of Human Rights) is considered, after an independent assessment, to be a necessary and proportionate response in their best interests to protect them from harm.

12.2 These safeguards cannot be used to detain people in hospital for the treatment for a mental disorder in situations where the Mental Health Act 1983 could be used if they are thought to object to being in hospital or to receiving treatment.

12.3 This will mean that people who object will be treated in broadly the same way as people with capacity who are refusing treatment for mental disorders and who need to be detained as a result.

12.4 People who need to be covered by the deprivation of liberty safeguards will mainly be those with significant learning disabilities or people suffering from dementia but will include a minority of others who have suffered physical injury, such as acquired brain injury.

12.5 The deprivation of liberty safeguards do not apply to people other than those identified within the above categories, for example; those living within their own home, a sheltered or a very sheltered housing scheme. Should a person in such a setting currently be, or at risk of being, deprived of their liberty then an application should be made to the Court of Protection.

13. Mental Capacity

13.1 For clarification of capacity issues, staff should see chapter 4 of the MCA Code of Practice in relation to the Mental Capacity Act (MCA) 2005.

13.2 In accordance with the Five Statutory Principles in the MCA 2005, the initial assumption must always be that a person has the capacity to make a decision, unless it can be established that they lack capacity.

13.3 Capacity is assessed in relation to an individual’s capacity to make a particular decision at the time it needs to be made and is judged on objective criteria, rather than on the basis of assumptions regarding age, appearance, condition or behaviour.

13.4 There is a two-stage test for capacity:

(i) Does the person have an impairment of the mind or brain, or is there some sort of disturbance affecting the way their mind or brain works? (Whether it is on a temporary or permanent basis.)

(ii) If so, does the impairment or disturbance mean that the person is unable to make the decision in question – in this case, whether they should receive care or treatment that involves depriving them of their liberty – at the time it needs to be made?
14. Documenting Capacity Assessments

14.1 The First Statutory Principle of the MCA 2005 is that there is an assumption of capacity. It is therefore important for staff to record any reasons for considering that a person does not have capacity in relation to a specific decision.

14.2 Where there is evidence of impaired decision-making capacity, this evidence should be recorded.

14.3 The MCA Code of Practice states, that “where assessments of capacity relate to day to day decisions and caring actions, no formal assessment procedures or recorded documentation will be required.” However, it goes on to state that the more important a decision is, the greater the need for clear recordings and that it is “good practice that a proper assessment of capacity is made and the findings of that assessment are recorded in the relevant professional records.” A Mental Capacity Assessment Form is available on CareFirst. Norfolk County Council staff should read the Mental Capacity and Mental Capacity Assessments Procedure for further information on this form.

14.4 It is important to note that the diagnostic test for capacity does not always involve the assessment of the person by a doctor. An informal carer, paid carer, social worker or other decision maker may have available to them sufficient information to determine that a person suffers from a condition or a disability that affects their decision making ability. It is inappropriate to subject a person to repeated medical or psychiatric assessments where there is sufficient information for the decision-maker to determine their capacity.

14.5 All attempts to assist a person to make the decision for themselves, should be recorded.

15. Best Interests

15.1 The Fourth Statutory Principle of the MCA 2005 is that any act done for, or any decision made on behalf of a person who lacks capacity must be done, or made, in that person’s “best interests”.

15.2 Chapter 5 of the MCA Code of Practice states that a person who is trying to determine the best interests of a person who lacks capacity to make a specific decision should:

- Encourage participation;
- Identify all relevant circumstances;
- Find out the person’s views, where possible;
- Avoid discrimination;
- Assess whether the person might regain capacity;
- Ensure that decisions regarding life-sustaining treatment are not motivated by a desire to bring about the person’s death;
- Consult others;
- Avoid restricting the person’s rights.
15.3 It is the decision-maker’s decision as to what is in the “best interests” of a person who lacks capacity. The identity of the decision maker will vary with the type of decision being made. For most day to day care decisions this will be the family carer or paid carer, with regard to medical treatment it will be the responsible health care professional and where an attorney or deputy has been appointed under a Lasting Power of Attorney or by the Court of Protection, it will be the Attorney or Deputy if the decision falls within the scope of their authority.

15.4 It is possible for a decision to be made by joint decision makers, for example when putting together a care plan for a person who lacks capacity which involves input from different Health and Social Care staff. It is essential that clear recording identifies each of the decision-makers involved, with regard to the specific decisions and the reasons for reaching those decisions that are in the “best interests” of the person who lacks capacity are met.

16. **Least Restrictive Principle**

16.1 The Fifth Statutory Principle of the Mental Capacity Act 2005 states that:

“before the act is done or the decision is made regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person’s rights and freedom of action.”

16.2 Section 5 of the Mental Capacity Act provides legal protection for those people who care for, or treat someone who lacks capacity, provided that the Act’s principles are followed and that the action is taken in the person who lacks capacity’s “best interests”. However as identified in this policy document, the Mental Capacity Act can only be used to restrain people to the extent that the restraint is:

• Necessary to protect the person who lacks capacity from harm and
• It is in proportion to the likelihood and seriousness of that harm.

16.4 Section 5 of the Act does not give protection to decision makers for actions that deprive a person of their liberty, unless a standard and/or an urgent authorisation is obtained (for information on how to apply for an Authorisation, go to www.norfolk.gov.uk/mentalcapacityact then click Deprivation of Liberty Safeguards). DOLS applications and notices by Managing Authorities may now be made online using Norfolk’s e-DOLS system.

17. **Mental Health Act 1983 (MHA) or Mental Capacity Act 2005 (MCA)?**

17.1 Because the Mental Capacity Act does not authorise people who lack capacity to be provided with care or treatment that deprives them of their liberty, it may be necessary to think about using the MHA to detain and treat somebody who lacks capacity to consent to treatment in circumstances where:-

(i) it is not possible to give the person the care or treatment for their mental disorder they need without doing something that might deprive them of their liberty;
(ii) The person needs treatment for their mental disorder that cannot be given under the Mental Capacity Act (for example because they have made a valid advance decision to refuse an essential part of the treatment);

(iii) The person may need to be restrained in a way that is not allowed under the Mental Capacity Act;

(iv) It is not possible to assess or treat the person safely or effectively without treatment being compulsory, e.g. because the person is expected to regain capacity to consent, but might then refuse to consent;

(v) The person lacks capacity to decide on some elements of the treatment associated with a mental disorder but has capacity to refuse a vital part of it, and they have done so;

or

(vi) There is some other reason why the person might not get treatment for their mental disorder, and they or somebody else might suffer harm as a result.