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Practice Guidance

Preparing for the Liberty Protection Safeguards

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PRACTICE GUIDANCE

Preparing for the Liberty Protection Safeguards

Key points

Local authorities should:

- Continue to use existing Deprivation of Liberty Safeguards (DoLS)/Court of Protection processes until April 2022.
- Keep sight of the ***Mental Capacity Act 2005*** (MCA) and consider reviewing:
  - how well practitioners know the MCA
  - what support practitioners need to develop their knowledge and confidence in using the MCA
  - how well people are being consulted when subject to a DoLS authorisation.

Suggestions for planning:

- Plan how colleagues will **work together across children's and adult services** in supporting young people aged 16-17 to whom Liberty Protection Safeguards (LPS) may apply.
- Prepare for reform by working together with partner agencies across the system – this is especially important for **Safeguarding Adults Boards.**
- Carry out **local impact assessments.**

This practice guidance aims to support senior leaders, supervisors and practitioners with planning for the implementation of the incoming **Liberty Protection Safeguards** (LPS).

As of February 2021, the *Code of Practice* and regulations has not been published, so full information on the LPS and how they will be implemented is not yet available. However, some of the requirements that will apply are already known. This resource provides a background to the LPS and informs readers about practice-related implications. It also outlines tasks that can help organisations to prepare for the LPS ahead of their introduction in **England and Wales** in **April 2022.**

The following are covered:

1. The background to the LPS

In 2014, in the Supreme Court Judgment known as 'Cheshire West' **([2014] UKSC 19)**, Lady Hale emphasised that 'human rights are for everyone' and the case led to a stronger emphasis on the safeguards to protect the Article 5 rights to liberty and security ***(Human Rights Act 1998 (HRA))***, of people who:

- lack capacity to consent to their care or treatment, and
- live in circumstances that amount to a deprivation of liberty.

The Cheshire West judgment **([2014] UKSC 19)** widened the number of people understood to be deprived of their liberty (Law Commission, 2017) and confirmed that the same test should apply in all settings, including in the community.

A consequence of this was 'a tenfold increase in the number of DoLS applications being made', which left local authorities and the Court of Protection struggling 'to cope with the resource implications of the judgment and a very large backlog of cases' and routine breaches in statutory timescales (Human Rights Joint Select Committee, 2018; NHS Digital, 2016).

In order to address this, and the criticisms of the DoLS regime that were made at the same time by the House of Lords in its **post-legislative scrutiny** of the ***Mental Capacity Act 2005*** (MCA), the Law Commission was asked to review the DoLS and make recommendations about law reform in this area. Concurrently, the Government also commissioned an independent review of the ***Mental Health Act 1983*** (MHA) which culminated in a **final report** in 2018 and in January 2021 a **white paper** setting out the Governments aspirations for reforming the MHA.

The independent review made proposals relating to the interface between the MHA and the MCA, which the government also considered in relation to the deprivations of liberty law reform. Although the recommendations in the Law Commission's **final report** (2017) were not agreed in full, it has led to significant reform, as outlined under the ***Mental Capacity Amendment Act (2019)***. The drafting of the regulations and guidance is still ongoing.

2. What are the LPS and why are they replacing DoLS?

The LPS apply in **England and Wales.** They concern care or treatment arrangements that deprive a person of their liberty where they are assessed to lack capacity to consent to or refuse the particular 'arrangements' in question. Like DoLs, the LPS will only authorise deprivations of liberty, not individual acts of care and treatment. As such, mental capacity assessments will still need to be carried out in relation to a person's ability to consent to the care and treatment in question. Where a person is found to lack capacity, **best interest decisions**, under the MCA, must be made and recorded.

The LPS are designed to ensure safeguards are in place that protect people from having their rights and freedoms restricted beyond what is **reasonable and proportionate** to keep them safe. The LPS have a wider scope than DoLS. **The LPS apply to:**

- **All settings - including hospitals, care homes and community settings.**
- **Everyone over 16 years old.**

The widening of scope to include people between 16 and 17 under the LPS will have implications for practitioners, both those working under the ***Children Act 1989*** and those working with children with Special Educational Needs and Disabilities under the ***Children and Families Act 2014***.

Case law has determined that parental consent is not enough to authorise a deprivation of liberty for 16 and 17-year-olds. This **Deprivation of liberty and 16-17 year olds: Practice Guide (2020)** explores this in more detail, and also outlines the steps which need to be taken before the LPS come into force to authorise deprivation of liberty in relation to 16 and 17-year-olds.

An LPS arrangement might cover:

- Where a person is to live in circumstances of confinement - this can be in one or more particular places.
- Where a person is to receive care or treatment in circumstances of confinement - this can be at one or more particular place.
- How a person is to be transported to a particular place, or places, to receive care or treatment in circumstances of confinement.

The LPS are intended to reduce the duplication of assessment, as well as to enable the authorisation of deprivation of liberty in multiple places.

The LPS are intended to be everyone's business. The aspiration is that thinking about deprivations of liberty will begin with practitioners at the care and support planning stage, rather than as part of a separate process after a deprivation of liberty arrangement is already in place.

3. An update on the implementation of the LPS

The LPS will replace the DoLS under the ***Mental Capacity Amendment Act (2019)***. At the date of publication of this resource (February 2021) it is expected that **full implementation of the LPS will take place in April 2022**. The government has **announced** that 'some provisions, covering new roles and training, will come into force ahead of that date' and that a twelve week 'public consultation on the draft regulations and Code of Practice for LPS' will run.

4. What are the transitional arrangements?

From April 2022 all new deprivation of liberty applications will be considered under the LPS; until then deprivation of liberty authorisations will continue under existing DoLS/Court of Protection arrangements. At present, and in the circumstances of the pandemic, additional guidance on **The Mental Capacity Act (2005) and deprivation of liberty safeguards (DoLS) during the coronavirus (COVID-19)** also needs to be considered as part of existing DoLS processes. This guidance does not alter the processes, but outlines when and how (for instance) assessments for those processes can be carried out remotely.

Any deprivation of liberty arrangements already in place in April 2022 will continue to apply until they are reviewed. As a deprivation of liberty under DoLS arrangements must be reviewed within twelve months, all existing DoLS authorisations should cease or transition to LPS arrangements by 1st April 2023.

5. What determines if an application for a deprivation of liberty under the LPS is necessary?

What constitutes a deprivation of liberty is not defined under the LPS. The Cheshire West Supreme Court ruling **([2014] UKSC 19)** and the LPS Code of Practice (when released) will guide practitioners with regards to this.

When determining whether an LPS authorisation is required, the following questions must be considered:

1. **Is this person confined under arrangements being made to enable their care and treatment?** Are they:

    a. Under continuous supervision and control?
    b. Not free to leave a place (or places) for a non-negligible period of time?

2. **If they are confined, can they consent?**

    a. If they have capacity to decide whether to consent and do, they are not deprived of their liberty and no LPS authorisation is required.
    b. If they have capacity to decide whether to consent and decide **not to consent**, they will be deprived of their liberty but the LPS cannot be used. It may be they meet the criteria for admission under the MHA but, if they do not, legal advice needs to be sought as to what can be done.

3. If they do not have capacity to decide whether or not to consent, then the question needs to be asked whether the confinement is imputable to the state - in other words:

    a. Are the arrangements being put in place by a public body, such as a local authority or NHS body?
    b. If they are being put in place by private individuals (for example in a person's own home) is the state aware, or ought it to be aware, of the arrangements?

If the answers to the questions above show the person is confined under arrangements to which they cannot consent, and for which the state is either directly or indirectly responsible, a LPS authorisation will be required.

4. **Can this deprivation of liberty be authorised using LPS?**

    a. If the person is being admitted to hospital and deprived of their liberty there for the purposes of treating or assessing a 'mental disorder', and they object to either the admission or all or part of the treatment, the MHA must be used rather than LPS.

    b. For LPS to be used the person must lack capacity to consent to the arrangements.

    c. The person must have a '**mental disorder**', as defined under the MHA. As the 'learning disability exception' within the MHA does not apply to LPS, this could be a learning disability which is not associated with 'abnormally aggressive' or 'seriously irresponsible conduct'.

    d. The arrangements must be '**necessary** to **prevent harm** to the cared-for person and **proportionate** in relation to the likelihood and seriousness of harm to the cared-for person' under **Schedule AA1 of the MCA.** Preventing harm is as important as ensuring the proposed intervention is necessary and proportionate. If the primary purpose of the arrangements is to prevent harm to other people, then the LPS cannot be used; it may, depending upon the circumstances, be necessary to consider using the MHA or seeking a court order.

The LPS does not apply if they conflict with a requirement imposed by a **community treatment order** or **guardianship** under the MHA.

6. Who authorises a person to be deprived of their liberty?

Deprivations of liberty under the LPS must be authorised by a '**responsible body**'. Different arrangements are in place for different settings. The responsible body for:

- NHS hospitals is the **hospital trust**.
- Continuing Health Care is the **Clinical Commissioning Group** in England and the **Health Board** in Wales.
- Care homes, supported living schemes, private hospitals and other settings (including where people are self-funders) is a **local authority**. There are detailed rules in the LPS provisions (for example, **Schedule AA1**) for identifying which local authority will be responsible in any given circumstance. The Code of Practice, when published, will also provide clarity around this issue.

The Government had initially intended to allow the coordination of some parts of the process to be delegated in certain cases to care home managers. However, it was announced in October 2020 that the decision had been taken not to bring into force the relevant provisions in April 2022; it may be that they are brought into force at a later point.

7. What does the LPS process involve?

Though not necessarily carried out in this order, the responsible body must ensure the following are carried out:	
Identification of whether:	> The person is over 16. > The proposed arrangements amount to a deprivation of liberty **(see section 5)**. > Any deprivation of liberty to which the person is subject to on an inpatient admission to hospital should, instead, be authorised under the MHA. > The arrangements would interfere with decisions made under the MHA in relation to a person subject to a provision of the MHA but not actually detained in hospital (such as **s.17** leave or conditional discharge).
Consultation with the person and a list of others.	Set out in the statute but, broadly, people interested in the welfare of the cared for person.
A mental capacity assessment.	(Who will complete this will be specified in regulations, not yet published at the time of writing), to determine whether the person lacks capacity as defined under the MCA to consent to the arrangements which deprive them of their liberty.
A mental health assessment.	To determine whether the person has a '**mental disorder**', as defined under the MHA (completed by a medical professional, satisfying requirements to be set out in regulations).
An assessment of whether the proposed arrangements are *necessary* and *proportionate*.	To prevent harm to the person.

The LPS provides for the ability to draw upon pre-existing assessments in relation to capacity and 'mental disorder', where it is **reasonable** to do so. In deciding whether it is reasonable to rely upon an earlier assessment, it will always be important to consider, above all, whether either the person's cognitive condition or their circumstances have changed. It is not possible to rely upon an earlier assessment in relation to the necessity and proportionality of the deprivation of liberty, because this would be so fact-specific.

Following this, assuming the assessments above find that the LPS route is appropriate, there will be:

- A draft authorisation produced.
- A pre-authorisation review (of the draft authorisation) – this may be a desk-based review of the paperwork, unless the review is to be carried out by an **Approved Mental Capacity Practitioner** (AMCP, explained in **section 11**). It must always be carried out by someone who is not involved in the day-to-day care of, or in providing any treatment to, the person.
- Authorisation by the responsible body (where the responsible body, outlined below, is satisfied this is necessary).

An AMCP must become involved in the following circumstances:

- Where it is 'reasonable to believe' the person doesn't want to live in the proposed place or receive care and treatment there.
- Where the arrangements are to be implemented in a private hospital (whether or not there is reason to believe the person might not wish to receive care and treatment there).
- Where the responsible body has referred the person to the AMCP and the AMCP has accepted.

In almost all circumstances, if an AMCP is involved, they will see the person. They can also carry out any other steps that they need to in order to decide whether the conditions for authorisation are made out.

8. If a deprivation of liberty is necessary under the LPS, what protections are there for the person?

Regardless of who the responsible body is, there are protections in place for the person. Except in very limited circumstances, the person should also be represented and supported either by:

- an appropriate person, i.e. a family member or friend; or
- an **Independent Mental Capacity Advocate** (IMCA), if there is no appropriate person to support the person.

Except in very limited circumstances, the appropriate person can also call on support from an IMCA in order to help them discharge their role.

If there are disagreements over the LPS arrangements, and if they have not already been involved, an AMCP may review the arrangements. An application can also be made to the **Court of Protection**, either by, or on behalf of, the person themselves, or by someone interested in their welfare.

9. What are the LPS renewal arrangements?

A major difference from DoLS is that it is possible for an LPS authorisation to be renewed. An LPS authorisation can run for a maximum of twelve months in the first instance. It could then be renewed for a maximum of a further twelve months, and then for up to three years at a time. It would only be appropriate for a lengthy renewal to be authorised where the arrangements for the person are well-established, stable, and are ones with which the person appears to be content.

10. LPS equality analysis

To fulfil the **Public Sector Equality Duty** under the ***Equality Act 2010*** (EA) the Department of Health and Social Care conducted an **analysis of the impact of the *Mental Capacity Amendment Bill (2018)***. This Bill has now passed into law in the form of the ***Mental Capacity Amendment Act (2019)***; however, the equality analysis remains relevant as it:

- assesses the expected impact of the reforms on people with protected characteristics (age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation) under the EA, and
- considers the Secretary of State's duty to 'have regard to the need to reduce health inequalities under the ***National Health Service Act 2006*** and **the Family Test**'.

The analysis acknowledges that people who lack capacity, but do not have a disability as defined under the EA, will also be affected by the Bill. It also recognises that **the following people will experience a disproportional impact as a result of the Bill:**

- people with a physical disability
- people with a learning disability or autism
- older people.

It also highlights that the Bill may operate differently for different groups. For example, people with long-term conditions from which they are unlikely to recover may have their authorisation renewed for up to three years following two initial one year authorisations. As result of the equality analysis, to mitigate the risk of longer authorisations becoming inappropriate if a person's condition changes, it has been decided longer authorisations will only be renewed where it is unlikely there will be a significant change in the person's condition. The report describes this as a proportionate approach that will reduce 'the burden of potentially invasive assessments upon people with long-term and stable conditions and their families'.

All deprivations of liberty for young people aged 16-17 are currently overseen by the Court of Protection. The report notes that the government will need to work with stakeholders to ensure the protections the current robust system offers 16-17 year olds isn't eroded by the introduction of the new system. This will in part be achieved through an 'especially powerful' duty to consult when considering the deprivation of liberty of 16-17 year olds.

The report also draws on feedback from Black, Asian and minority ethnic groups that 'people from their communities have a preference to receive care in their own home' and highlights that people from these groups are under-represented in the current Deprivation of Liberty Safeguards system. The report states that the new system will improve the experience of people from Black, Asian and minority ethnic communities by the removal of the need to go to court to authorise a deprivation of liberty in the community, therefore increasing the number of authorisations in these communities.

People with mental health difficulties who are subject to the ***Mental Health Act 1983*** (MHA) will also be treated differently by the Bill, as any deprivation of liberty required for their care or treatment will be authorised under the MHA. The report highlights that 'while people with mental illnesses might be subject to different legislation, they will still have access to legal safeguards and protections as required by **Article 5** and so will not be disadvantaged by the Bill'.

The Department of Health and Social care's **Planned Milestones Diagram** states that a revised impact statement will be published. The report has set out a commitment to 'engage with stakeholders to consult and update documentation as appropriate' as amendments to the Bill are considered.

11. Preparing for the LPS

Under the **Mental Capacity Amendment Act (2019)** Best Interest Assessors (BIAs) will no longer exist. People in these roles are likely to be in a good position to requalify to become the new Approved Mental Capacity Practitioners (AMCPs). There are, however, crucial differences between BIAs and AMCPs. Unlike with DoLS, where every person has a BIA scrutinising the process, under the LPS scrutiny by an AMCP will only take place in specific circumstances - most notably in cases where 'it is reasonable to believe' that the person doesn't want to reside in the place or where there are disagreements about the person's proposed care or treatment. Also, whilst each local authority must approve enough AMCPs for their area, they will not necessarily be employed by that local authority – they could be employed by hospital Trusts, CCGs or private hospitals.

Under the MCA, as it will stand as of April 2022, deprivations of liberty will be only be permitted without formal authorisation in circumstances where arrangements are required either to carry out life-sustaining treatment or to prevent a serious deterioration in the person's condition to which it is reasonably believed that the person cannot consent, and:

- Steps are being taken to coordinate the assessment process for an LPS authorisation, but the process is not yet complete.
- An application has been made to the Court of Protection to decide what steps should be taken; or
- It is an emergency (there is 'urgent need' and there has not been the time to start the process of assessment for purposes of the LPS). If the deprivation of liberty then continues after the emergency has been resolved, it will only be permitted under the MCA in one of the two circumstances set out immediately above.

The Statutory Code of Practice should provide more information on what constitutes these situations.

Senior leaders will need to plan strategically in order to prepare their organisations for the LPS related changes ahead. This will be especially important for **Safeguarding Adults Boards**. Preparing for reform by working together and sharing expertise with the following colleagues across the system is likely to be beneficial:

- The local authority
- Clinical Commissioning Group
- Hospital Trust
- Care provider organisations
- Police
- Prisons, as it is possible that arrangements for securing care and treatment in prison will require authorisation under the LPS
- Ambulance services.

It is also likely to be beneficial to carry out local impact assessments to determine:	
How many hospices and independent hospitals are there in your local area?	Including those supporting people with mental health difficulties, physical needs, a learning disability or autism.

How many people in your local area may be subject to LPS?	For example, people:
	- living in:
	  - care homes
	  - supported living services
	  - extra care housing services
	  - their own homes with restrictive care or support in place (including those supported by family members at home, as is disproportionately the case for people from Black, Asian and ethnic minority communities).
	- currently in hospitals
	- aged 16 and 17
	- funded by **Continuing Health Care**
	- who are self-funded

How many AMCPs will be required?	It may also be helpful to explore how many BIAs may be interested in taking further training in order to become AMCPs following the publication of the LPS guidance and regulations.

Questions for reflection

Reflecting on the following questions may also help organisations prepare for the incoming LPS:

1. How well do you and your colleagues know the MCA?
2. How confident are practitioners across the system in using the MCA effectively, including those working in children's services?
3. How will people with a physical disability, a learning disability or autism, older people and people from Black, Asian and ethnic minority communities, be supported to know about the new safeguards and the impact they may have on their lives/that of their communities?
4. How will colleagues work together across children's and adult services in supporting young people aged 16-17 to whom LPS may apply?
5. How can you support discussion and reflection where there may be conflict and complexity around mental capacity and DoLs? This **SCIE film** may support these reflections.
6. How well are people being consulted when subject to a DoLS authorisation?

When the Code of Practice and Regulations are published they will go through a public consultation. The final versions of these documents will provide more detail on how the ***Mental Capacity Amendment Act (2019)*** will be implemented.

Research in Practice **Policy Updates** and **Case Law and Legal Summaries** will support people wishing to keep up-to-date with developments in this area as they unfold. The **Mental Capacity Law and Policy website** also provides an up-to-date overview of the LPS and includes links to government newsletters and factsheets.

Further Research in Practice resources

Legal Literacy: Change Project (2020)

Liberty Protection Safeguards: Webinar (2020)

What are the Deprivation of Liberty Safeguards (DoLS)? Brief Guide (2014)

What are the Deprivation of Liberty Safeguards (DoLS)? Brief Guide – Easy Read (2017)

References

Department of Health and Social Care (2018). *Modernising the Mental Health Act: Increasing choice, reducing compulsion. Final report of the Independent Review of the Mental Health Act 1983.*
www.gov.uk/government/publications/modernising-the-mental-health-act-final-report-from-the-independent-review

NHS Digital (2016). *Mental Capacity Act (2005) Deprivation of Liberty Safeguards (England): England 2015-16 National Statistics.*
digital.nhs.uk/news-and-events/news-archive/2016-news-archive/latest-statistics-for-the-deprivation-of-liberty-safeguards-published-by-nhs-digital

The Law Commission (2017). *Mental Capacity and Deprivation of Liberty.*
www.lawcom.gov.uk/app/uploads/2017/03/lc372_mental_capacity.pdf

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