Briefing for providers on the Deprivation of Liberty Safeguards

4 April 2014

Issue

On 19 March 2014, the Supreme Court handed down its judgment in the case of "P v Cheshire West and Chester Council and another" and "P and Q v Surrey County Council".

Download the full judgment from the Supreme Court website

The judgment is significant for deciding whether arrangements made for the care and/or treatment of an individual who might lack capacity to consent to those arrangements amount to a deprivation of liberty.

A deprivation of liberty for such a person must be authorised in accordance with one of the following legal regimes: a deprivation of liberty authorisation or Court of Protection order under the Mental Capacity Act Deprivation of Liberty Safeguards, or (if applicable) under the Mental Health Act 1983, or, in some rare situations, under the inherent jurisdiction of the High Court.

Information for providers

Following the Supreme Court judgement on 19 March 2014, health and social care staff must be aware of how you should now judge whether a person might be deprived of their liberty.

It is clear that the intention of the majority of the Supreme Court was to extend the safeguard of independent scrutiny. They said: "A gilded cage is still a cage" and that "we should err on the side of caution in deciding what constitutes a deprivation of liberty". They also highlighted that a person in supported living might also be deprived of their liberty. **It is certain that many more requests for authorisations under the deprivation of liberty safeguards will be made for people in hospitals or care homes, and that many more applications will be made to the Court of Protection for those in domestic settings with support.**

The deprivation of liberty safeguards apply only in hospitals and care homes but these criteria can help you decide if there is a deprivation of liberty, in any setting.

(1) It is critical to separate the question of whether restrictions amount to a deprivation of liberty from whether staff actions are necessary, proportionate, and in the person's best interests. The former determines whether the situation needs to be authorised: the latter whether it will be. The most important step for providers who suspect that they may be depriving someone of their liberty is to reduce restraint and any restriction on the person's freedoms as far as possible, using the MCA best interests process to hear all opinions.

(2) Where it seems likely that a person is (or will be) being deprived of their liberty *in a care home or a hospital*, and this seems to be in the person's best interests, a referral to the Local Authority deprivation of liberty safeguards team should be (or should have been) made by the provider. If they have not done so even after prompting, a third party, such as a CQC inspector, can contact the local authority directly. The provider must notify CQC of the application made and the outcome.

(3) For all other settings, such as supported living, adult placement/shared lives or domiciliary care, the deprivation of liberty safeguards cannot be used, so an application must be made to the Court of Protection. In these settings, providers are advised to seek legal advice and liaise with the commissioners of the service if they think they might be depriving someone of their liberty and cannot find a less restrictive option for providing care or treatment. While this is happening, they must continue to provide care and attention to the person.

(4) The cases that came before the Supreme Court all related to people with learning disabilities. It is clear, however, from the way the deprivation of liberty safeguards are used already, that the many of the people who might be deprived of their liberty in their own best interests are older people, often in care settings (currently about 75% of all authorisation requests) but, following this judgement, some are likely to be identified in domestic settings with support. They are living with dementia or with acquired brain injury, for example from a stroke, or with neurological conditions such as Parkinson's disease or Huntington's disease; they often have complex health and care needs.

Care providers and local authority care managers should examine the situation of people who lack the mental capacity to agree to their living arrangements, to see if they fit the Supreme Court's test below.

(5) In a psychiatric inpatient setting, clinical staff should review the situation of all informal patients who lack mental capacity to consent to admission, and consider if they are deprived of their liberty. If they are at risk, the first step is to carefully scrutinise the care plan to see if this could be safely altered to reduce the restrictions so there is no longer a deprivation of liberty. If this is not possible then you must decide between using the Mental Health Act and the MCA deprivation of liberty safeguards. The criteria for deciding between these have not been changed by this judgement. Professionals should not assume one regime is "less restrictive" than the other. It is the care plan which imposes the restrictions, not the procedural safeguards that are required if these restrictions amount to a Deprivation of Liberty.

What is deprivation of liberty?

The DoLS Code of Practice lists the factors which may indicate a deprivation of liberty: these are still relevant but must now be read in the light of this decision of the Supreme Court.

The Supreme Court has now confirmed that there are two key questions to ask:

Is the person subject to continuous supervision and control? *All three elements must be present – the oversight must be continuous (though does not have to be 'in line of sight'), it must amount to supervision, and have a clear element of control.*

AND

Is the person free to leave? *The person may not be asking to go or showing by their actions that they want to but the issue is about how staff would react if the person did try to leave or if relatives/friends asked to remove them.*

It is now clear that if a person lacking capacity to consent to the arrangements is subject both to **continuous supervision and control *and* not free to leave,** they are deprived of their liberty.

It may not be a deprivation of liberty, although the person is not free to leave, if the person is not supervised or monitored all the time and is able to make decisions about what to do and when, that are not subject to agreement by others.

The Supreme Court ruled that the following factors are no longer relevant to whether or not someone is deprived of their liberty:

(1) the person's compliance or lack of objection;

(2) the suitability or relative normality of the placement (after comparing the person's circumstances with another person of similar age and condition);

and

(3) the reason or purpose leading to a particular placement

though of course all these factors are still relevant to whether or not the situation is in the person's best interests.

If a provider knows that someone coming in to their care may be deprived of liberty the authorisation should be in place before the person arrives.

Providers must note that authorisations under the Mental Capacity Act are NOT transferrable. Those given under the deprivation of liberty safeguards only cover that particular hospital or care home. Court Orders only cover what they say they cover.

This is not a full statement of law but is designed to help providers understand the practical implications of the Supreme Court judgement.

Annex: The examples which the Supreme Court decided were deprivation of liberty

1. An adult (P) with a learning disability living in a bungalow with two other residents, with two members of staff on duty during the day and one 'waking' member of staff overnight. He requires prompting and help with all the activities of daily living, getting about, eating, personal hygiene and continence. P requires further intervention including restraint to stop him harming himself, but is not prescribed any tranquilising medication. He is unable to go anywhere or do anything without one to one support; he gets 98 hours a week of personal support to enable him to leave the home frequently for activities and socialising.
2. A 17 year old (Q, or MEG) with mild learning disabilities living with three others in an NHS residential home for learning disabled adolescents with complex needs. She has occasional outbursts of aggression towards the other three residents and then requires restraint. She is prescribed (and administered) tranquilising medication. She has one to one and

sometimes two to one support. Continuous supervision and control is exercised so as to meet her care needs. She is accompanied by staff whenever she leaves. She attends a further education unit daily during term time, and has a full social life. She shows no wish to go out on her own, but she would be prevented from doing so in her best interests.

3. An 18 year old (P, or MIG) with a moderate to severe learning disability and problems with her sight and hearing, who requires assistance crossing the road because she is unaware of danger. She lives with a foster mother whom she regards as 'mummy.' Her foster mother provides her with intensive support in most aspects of daily living. She is not on any medication. She has never attempted to leave the home by herself and showed no wish to do so, but if she did, her foster mother would restrain her in her best interests. She attends a further education unit daily during term time and is taken on trips and holidays by her foster mother.