journey to change

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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Title: Deprivation of Liberty

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Contents

1 Introduction

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. The judgment is significant in identifying whether the arrangements made for the care and/or treatment of a person who lacks the capacity to consent to those arrangements amounts to a deprivation of liberty.

The effect of this decision is to include more people within the definition of deprivation of liberty, particularly those service users in Mental Health Services for Older People (MHSOP) and Learning Disability (LD) services.

Our Journey to Change sets out that we want people to lead their best possible lives. Our first Strategic Goal 'To co create a great experience for our patient, carers and families' is central to what we do. For people that use our services, their carers and families, we want to ensure that through this policy we respect their rights and meet our legal obligations.

Identifying that a person is deprived of their liberty is not a criticism of their care. The law recognises that some people, who lack the capacity to consent to their care or treatment, will be deprived of their liberty in their best interests in order to provide them with care and treatment.

The definition of a deprivation of liberty develops over time in line with decisions by the European Court of Human Rights and UK courts on article 5 of the European Convention on Human Rights (EHCR). You must keep up to date with the latest case law developments.

2 Why we need this policy

2.1 Purpose

If a person who lacks the capacity to consent to the arrangements for their care or treatment is deprived of their liberty, that deprivation of liberty must be authorised.

An authorisation process means that the deprivation of liberty is subject to external scrutiny and safeguards the rights of the person.

A deprivation of liberty that is not authorised is unlawful.

A deprivation of liberty can be authorised by:

- A Deprivation of Liberty Safeguards (DoLS) authorisation;
- The Mental Health Act 1983 (MHA), where applicable and appropriate;
- The Court of Protection

Authorising a deprivation of liberty makes sure that there are independent checks and safeguards to make sure that the arrangements made are in the person's best interests.

2.2 Objectives

Chapter 13 of the MHA Code of Practice addresses mental capacity and deprivation of liberty. It notes at paragraph 13.2

> *Practitioners should be able to identify the legal framework that governs a patient's assessment and treatment and authorise any appropriate deprivation of a patient's liberty whether the MCA or MHA. The legal framework is not static and may change as the patient's circumstances and needs change.*

This document will help to ensure that:

- TEWV staff are able to identify when a deprivation of liberty occurs;
- All newly admitted patients are assessed in relation to the definition of deprivation of liberty;
- Informal in-patients are re-assessed on a regular basis in relation to the definition of deprivation of liberty.

3 Scope

This document gives guidance to practitioners around:

- Identifying when a deprivation of liberty is occurring
- Identifying the most appropriate means of authorising a deprivation of liberty

3.1 Who this policy applies to

- All Trust staff

Following this policy will help the Trust to provide compassionate care by supporting people who are deprived of their liberty.

3.2 Roles and responsibilities

Role	Responsibility
The Trust	• Make sure that any deprivation of liberty is authorised • Make sure that appropriate records are kept • Make sure that all parties are informed of details and outcomes of assessments
Ward and team managers	• To take all steps to minimise the restrictions imposed on a person • To ensure that any deprivation of liberty of a patient within their area is authorised

	• To ensure that appropriate support and representation is provided

4 Policy

4.1 What is a deprivation of liberty?

There is a deprivation of liberty where a person:

- Lacks capacity to consent to the arrangements made for their care and/or treatment; and
  - Is under continuous supervision and control; and
  - Is not free to leave

4.2 Capacity to consent to admission/remaining in hospital

For the care regime to amount to a deprivation of liberty, the person must be unable to give their consent to the arrangements made for their care or treatment.

Where a person has capacity and freely consents to the care and treatment regime there can be no deprivation of liberty under the Mental Capacity Act 2005 (MCA).

In order to give valid consent to admission to, or remaining in, a mental health unit the person must have the capacity to consent to the actual care and treatment regime that will be in place for them. Capacity is determined in accordance with the Mental Capacity Act 2005 (MCA).

Valid consent requires that the person is given sufficient information relevant to the decision and the information they are consenting in this instance to will include:

- That they are/will be in hospital to receive care and treatment for a mental disorder;
- The core elements of that care and treatment and measures which may be put in place to supervise the patient for example:
  - Prescription and administration of medication for the treatment of mental disorder;
  - Observation levels;
  - Time away from the ward may be escorted only;
  - Visits may be supervised;
- What steps may be taken in respect of searching of the patient and their property;
- What would happen if the patient tried to leave hospital

For consent to be valid it must also be freely given and the person must not be under any duress or inappropriate pressure.

Agreement given under duress or any other pressure is not consent.

4.3 'Continuous supervision and control'

It would be difficult to demonstrate that an in-patient setting in a mental health or learning disability ward does not amount to continuous supervision and control. Patients may well have time away from the ward where they could be said to be unsupervised, however this is controlled by staff ie, they cannot leave without the agreement of staff or without staff opening the door for them. Whilst on the ward, patients are supervised at all times ie, there is always a staff presence 24/7, 365 days per year, though this does not have to be on a 1:1 basis or within eyesight to meet the requirement for continuous. Staff supervise and control all aspects of ward life including meal times, access to fresh air, access to visitors, administration of medication, access to activities and agreed time away from the ward, and safety of the ward environment, to highlight just some elements.

4.4 'Not free to leave'

This is not determined by whether the person is attempting to leave and being prevented from doing so, but by what those people with control over their care arrangements would do **if** they attempted to leave.

In the context of the judgment, this does not mean free to leave to go to the local shops or into town, for example, it means free to leave (discharge themselves) to live/stay somewhere else and not return. There are a number of patients who have this level of freedom but we must consider the action we would take if they failed to return which in most instances would involve finding a means to return them, which may even include contacting the police.

There are, of course, patients who are free to leave i.e. if they asked to go home and not return we would not prevent them in any way. However, if at the time they told us of their intention to leave there were clear risks present related to their mental disorder, this would necessitate consideration of whether to use a holding power to lawfully prevent their leaving.

The judgment is also clear that free to leave doesn't just mean free to leave if they ask, it means even if they do not ask we must consider what we would do if they did ask.

Some patients are unable to express their desire to leave but we must consider them not free to do so if, were they able to ask, we would say no.

4.5 Things that are not relevant

The Supreme Court has said that these things are not relevant to whether a person is deprived of their liberty:

- The person is compliant, or not objecting to their care or treatment;
- The 'relative normality' of the placement;
- The reason or purpose behind a particular placement.

4.6 Examples

4.6.1 Mental Health Services for Older People example

Gill is a patient on an MHSOP ward. She has significant dementia, she neglects herself and has marked deterioration. She lacks capacity to consent to being in hospital. She does not object in any way to being in hospital, does not ask to leave, and does not make any attempt to leave. Her

admission and treatment is in her best interests and her family fully support all aspects of her care and treatment.

Before Supreme Court Decision
This would have been unlikely to be seen as a deprivation of liberty. The MCA would have provided sufficient authority to provide care and treatment in best interests.
After Supreme Court Decision
Gill is under continuous supervision and control. This is necessary to provide care and treatment and to keep her safe. She is not free to leave as the care team believe that she can only be looked after in hospital due to the severity of her dementia and sudden deterioration. **This is, therefore, very likely to be a deprivation of liberty and must be authorised.**

4.6.2 Learning Disability example

Dan has a moderate/severe learning disability and is on a Learning Disability Assessment and Treatment unit. He does not have capacity to consent to being there. He does not make any request or attempt (either verbally or physically) to leave. Staff manage his day to day regime, including meals, medication, encouragement to attend to personal hygiene, when to go to bed and when to get up.

Dan attends activities away from the ward daily and football and other sporting and social events at weekends, accompanied by staff, due to his tendency to become over-excited and run onto the road or approach strangers and try to give them money.

He has no family involved in his care and earlier placements in the community have broken down due to previous aggression. This has now reduced but still occurs occasionally.

Before Supreme Court Decision
This would have been unlikely to have been seen to amount to a deprivation of liberty and the MCA would have been sufficient authority to provide care and treatment.
After Supreme Court Decision
Dan is under continuous supervision and control in order to provide care and treatment and keep him and others safe. He will not be allowed to leave as he is vulnerable and could not care for himself or keep himself safe and has nowhere else to live. **This is, therefore, now very likely to be a deprivation of liberty and must be authorised.**

4.6.3 Respite Care example

Anne is 32 years old and has a learning disability. She is cared for by her parents in the family home, and is admitted to hospital on a regular basis for short periods of care (usually one week) every month in order to provide respite for her family and to ensure that their ability to provide care and support is maintained.

Anne does not have capacity to consent to her admission to hospital. Respite admissions are in her best interests and are fully supported by her parents.

Before Supreme Court Decision
This would have been unlikely to have been seen to amount to a deprivation of liberty and the MCA would have been sufficient authority to provide care and treatment in best interests.
After Supreme Court Decision

Anne will be under continuous supervision and control when admitted to respite care. It is possible that she is free to leave and return immediately to the care of her parents, and if this is the case she will not be deprived of her liberty.

If, for example, Anne's parents have agreed that if Anne shows any indication of wishing to leave or any signs of distress that might indicate that Anne wishes to leave, they can be contacted and they will take her back home at any and all times, Anne will be free to leave, and therefore not deprived of her liberty.

If, however, Anne's parents have clearly stated that they cannot have Anne back at home during the respite period as this time is essential for them to be able to cope with Anne the rest of the time, they will not be available to take Anne home immediately. This would mean that Anne is not free to leave. She is under continuous supervision and control and so is deprived of her liberty. Whilst the respite period of one week in this example may not be sufficient to amount to a deprivation of liberty, the cumulative effect of one week every month most likely would.

In these circumstances it is highly unlikely that the criteria for using the MHA will be met, so it is likely that the Deprivation of Liberty Safeguards would be used to authorise the deprivation of liberty.

In such circumstances a standard DoLS authorisation could be given for one year and would authorise the periods of deprivation of liberty whilst in respite care within that year.

4.6.4 Adult Mental Health Services example

John has bi-polar disorder and when presenting with symptoms of hypomania requires admission to manage his symptoms.

When presenting with symptoms of hypomania, John lacks capacity to consent to the decision to come into hospital but has frequently come into hospital on an adult mental health ward as an informal patient.

John is happy to take medication when in hospital; he gradually has time away from the ward, but only with staff accompanying him, due to his poor impulse control when unwell.

He doesn't ask to go home but he does ask to go out frequently, sometimes more frequently than staff can immediately accommodate, but he is easily persuaded to wait until staff are available.

Before Supreme Court Decision
This would have been unlikely to have been seen to amount to a deprivation of liberty and the MCA would have been sufficient authority to provide care and treatment in best interests.
After Supreme Court Decision
John is under continuous supervision and control in order to provide care and treatment and keep him safe. He is not allowed to leave without staff accompanying him as he is vulnerable when presenting with symptoms of hypomania. **This is, therefore, now very likely to be a deprivation of liberty and must be authorised.**

4.7 Assessment and reassessment

A patient must be assessed before being admitted to hospital to determine whether they have the capacity to consent to admission.

Patients who have already been admitted on the basis of their consent should be reassessed on a regular basis to make sure that they still have the capacity to consent to the arrangements for their care and treatment and that they do, in fact, still consent if there would be a deprivation of liberty if they could not/did not.

4.8 How can a deprivation of liberty be authorised?

If a deprivation of liberty has been identified either the elements contributing to the deprivation of liberty must be removed or the deprivation of liberty must be authorised.

The way in which a deprivation of liberty can be authorised depends on where that deprivation of liberty is occurring:

Community	Care Home	Hospital
• Court of Protection Order	• DoLS authorisation from Supervisory Body • Court of Protection Order	• DoLS authorisation from Supervisory Body • Mental Health Act 1983

4.8.1 Detention under the Mental Health Act 1983

If the patient has the capacity to consent to admission to hospital but is objecting to care or treatment for mental disorder, detention under the MHA is the only way to authorise the deprivation of liberty.

The MHA can also be used where the patient is consenting to admission/remaining in hospital if there are **significant risks** present. The MHA Code of Practice also notes:

> *Compulsory admission should, in particular, be considered where a patient's current mental state, together with reliable evidence of past experience, indicates a strong likelihood that they will have a change of mind about informal admission, either before or after they are admitted, with a resulting risk to their health or safety or to the safety of other people.*

4.8.2 Authorisation under the Deprivation of Liberty Safeguards

The DoLS can be used to authorise a deprivation of liberty in either a hospital or a care home. They can be used in these circumstances:

• The person is aged 18 or over; and
• Has a mental disorder; and
• Lacks capacity to consent to the arrangements made for their care or treatment in either a hospital or a care home; and

- For whom a deprivation of liberty is necessary in their best interests to protect them from harm; and
- There are 'no refusals' eg Advance Decision or donee of a lasting POA or deputy refusal, and
- Where they are eligible, ie not already detained under the MHA in a hospital, the authorisation does not conflict with a requirement of the MHA, or treatment is in a hospital for mental disorder and they do not object

4.8.3 Authorisation by the Court of Protection

Neither the MHA nor the DoLS can be used to authorise a deprivation of liberty in the community.

If a person is being deprived of their liberty in the community (this includes independent supported living) authorisation can only be given by the Court of Protection.

4.9 Decision making between MCA and DoLS or the MHA

There will only be limited circumstances in which a decision is required. All of the circumstances below must be present:

- The person is, or is likely, to be deprived of liberty in a hospital for care and/or treatment for mental disorder and is within the scope of the MHA;
- The person lacks capacity to consent to the arrangements made for their care or treatment;
- The person is wholly compliant with all aspects of care and treatment for mental disorder including medication, personal care, and being on or taken to the ward;
- The deprivation is not for the protection of others, but is in the person's best interests and in order to prevent harm to the person themselves.

Where all of the above are present then a decision is required regarding using the DoLS or the MHA to authorise the deprivation of liberty in hospital.

The decision must be made on a case by case basis taking into account each individual's circumstances and should not be based on a general preference for one regime or the other.

Decision-makers should not proceed on the basis that one regime is generally less restrictive than the other.

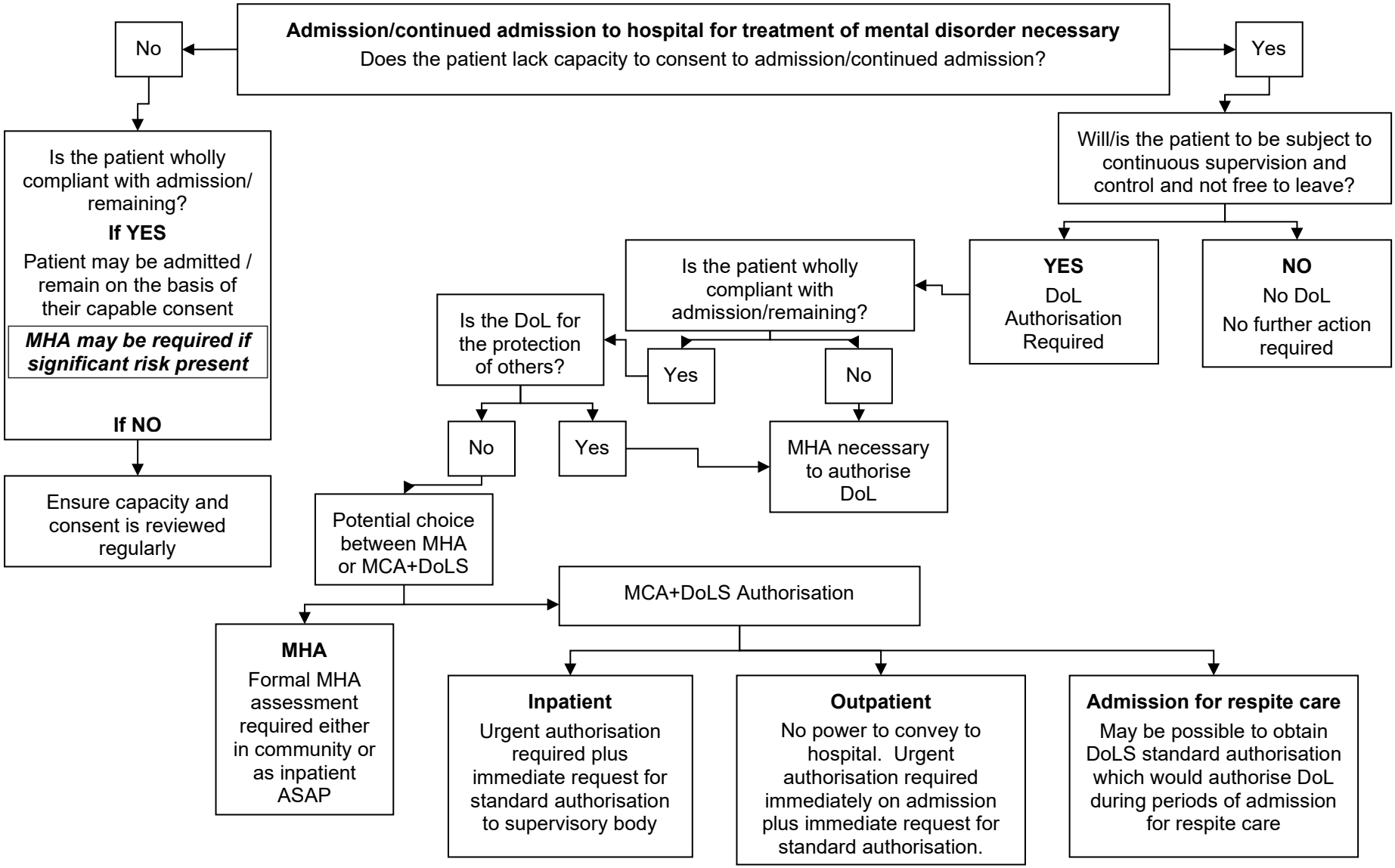
In some circumstances the MHA is the only option:

- Where the person is objecting to any element of care or treatment for mental disorder;
- Where the person has made a valid and applicable advance decision or appointed a donee under and LPA which prevents DoLS authorisation;
- Where the purpose of the deprivation of liberty is in the interests of others, ie to prevent harm to the others;
- Where authority for care or treatment is not covered by the MCA

You must also consider:

- The availability of DoLS. You may not be able to determine that DoLS is actually available. For example, a doctor in the community admitting a patient may have no influence over whether the inpatient team will use an urgent authorisation.
- The different nature of the safeguards provided under each regime and a determination based on professional judgment in deciding which safeguards are more likely to best protect the interests of the patient in the particular circumstances of each individual case.
- Fluctuating capacity. The MHA provides a more robust regime where a person gains and loses capacity. The DoLS and MCA may become unusable in such circumstances.

4.10 Decision making algorithm



5 Definitions

Term	Definition
Supreme Court	The Supreme Court is the final court of appeal in the UK for civil cases, and for criminal cases from England, Wales and Northern Ireland. It hears cases of the greatest public or constitutional importance affecting the whole population.
Court of Protection	The Court of Protection makes decisions and appoints deputies to act on behalf of people who are unable to make decisions about their personal health, finance or welfare. It can authorise a deprivation of liberty.
Deprivation of Liberty Safeguards (DoLS)	The Mental Capacity Act Deprivation of Liberty Safeguards were introduced into the Mental Capacity Act 2005 through the Mental Health Act 2007. The safeguards cover patients in hospitals, and people in care homes registered under the Care Standards Act 2000, whether placed under public or private arrangements.

6 Related documents

DoLS Procedure

7 How this policy will be implemented

- This policy will be published on the Trust's intranet and external website.
- Line managers will disseminate this policy to all Trust employees through a line management briefing.

7.1 Training needs analysis

Staff/Professional Group	Type of Training	Duration	Frequency of Training
All clinical staff with a professional registration	E-learning	3 hours	Every 2 years
All clinical staff without a professional registration	E-learning	3 hours	Every 2 years

8 How the implementation of this policy will be monitored

Auditable Standard/Key Performance Indicators		Frequency/Method/Person Responsible	Where results and any Associate Action Plan will be reported to, implemented and monitored; (this will usually be via the relevant Governance Group).
1	Monitoring the use of the MHA and DoLS.	MHL officer collate information	Reported to the MHLC each quarter

9 References

MHA Code of Practice
MCA Code of Practice
DoLS Code of Practice
P v Cheshire West and Chester Council and another and P and Q v Surrey County Council

10 Document control (external)

To be recorded on the policy register by Policy Coordinator

Date of approval:	18 May 2022	
Next review date:	18 May 2025	
This document replaces:	MHA-0012-v6 Deprivation of Liberty Policy	
This document was approved by:	Name of committee/group	Date
	Mental Health Legislation Committee	17 February 2022
This document was ratified by:	Name of committee/group	Date
	Management Group	18 May 2022
An equality analysis was completed on this document on:	17 February 2022	
Document type	Public	
FOI Clause (Private documents only)	n/a	

Change record

Version	Date	Amendment details	Status

7	18 May 2022	3 yearly review. Template updated to include Our Journey to Change.	Ratified

Appendix 1 - Equality Analysis Screening Form

Please note: The Equality Analysis Policy and Equality Analysis Guidance can be found on the policy pages of the intranet

Name of Service area, Directorate/Department i.e. substance misuse, corporate, finance etc.	Mental Health Legislation					
Policy (document/service) name	Deprivation of Liberty Policy					
Is the area being assessed a…	Policy/Strategy	X	Service/Business plan		Project	
	Procedure/Guidance				Code of practice	
	Other – Please state					
Geographical area covered	Trust wide					
Aims and objectives	The purpose of this policy is to ensure that: • TEWV staff are able to identify when a deprivation of liberty occurs; • All newly admitted patients are assessed in relation to the definition of deprivation of liberty; • Informal in-patients are re-assessed on a regular basis in relation to the definition of deprivation of liberty.					
Start date of Equality Analysis Screening (This is the date you are asked to write or review the document/service etc.)	October 2021					
End date of Equality Analysis Screening (This is when you have completed the equality analysis and it is ready to go to EMT to be approved)	**January 2022**					

You must contact the EDHR team if you identify a negative impact - email tewv.eandd@nhs.net

1. Who does the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit?

Patients who lack the capacity to consent or who refuse to consent to arrangements necessary for their care or treatment who may be deprived of their liberty.

2. Will the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups below?

Race (including Gypsy and Traveller)	No	**Disability** (includes physical, learning, mental health, sensory and medical disabilities)	No	**Sex** (Men, women and gender neutral etc.)	No
Gender reassignment (Transgender and gender identity)	No	**Sexual Orientation** (Lesbian, Gay, Bisexual and Heterosexual etc.)	No	**Age** (includes, young people, older people – people of all ages)	No
Religion or Belief (includes faith groups, atheism and philosophical belief's)	No	**Pregnancy and Maternity** (includes pregnancy, women who are breastfeeding and women on maternity leave)	No	**Marriage and Civil Partnership** (includes opposite and same sex couples who are married or civil partners)	No

Yes – Please describe anticipated negative impact/s

No – Please describe any positive impacts/s

3. Have you considered other sources of information such as; legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.? **If 'No', why not?**	**Yes**	**X**	**No**	

Sources of Information may include: • Feedback from equality bodies, Care Quality Commission, Equality and Human Rights Commission, etc. • Investigation findings • Trust Strategic Direction • Data collection/analysis • National Guidance/Reports	• Staff grievances • Media • Community Consultation/Consultation Groups • Internal Consultation • Research • Other (Please state below)

4. Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the following protected groups?: Race, Disability, Sex, Gender reassignment (Trans), Sexual Orientation (LGB), Religion or Belief, Age, Pregnancy and Maternity or Marriage and Civil Partnership

Yes – Please describe the engagement and involvement that has taken place

The Mental Capacity Act and the Deprivation of Liberty Safeguards were subject to extensive Equality Impact Assessment conducted on behalf of the Ministry of Justice.

No – Please describe future plans that you may have to engage and involve people from different groups

5. As part of this equality analysis have any training needs/service needs been identified?	
Yes	All clinical staff are required to completed mandatory MHL e-learning every 2 years.

A training need has been identified for;					
Trust staff	Yes	Service users	No	Contractors or other outside agencies	No
Make sure that you have checked the information and that you are comfortable that additional evidence can provided if you are required to do so					

Appendix 2 – Approval checklist

	Title of document being reviewed:	Yes/No/ Not applicable	Comments
1.	**Title**		
	Is the title clear and unambiguous?	Y	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Y	
2.	**Rationale**		
	Are reasons for development of the document stated?	Y	
3.	**Development Process**		
	Are people involved in the development identified?	Y	
	Has relevant expertise has been sought/used?	Y	
	Is there evidence of consultation with stakeholders and users?	Y	
	Have any related documents or documents that are impacted by this change been identified and updated?	Y	
4.	**Content**		
	Is the objective of the document clear?	Y	
	Is the target population clear and unambiguous?	Y	
	Are the intended outcomes described?	Y	
	Are the statements clear and unambiguous?	Y	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Y	
	Are key references cited?	Y	
	Are supporting documents referenced?	Y	
6.	**Training**		
	Have training needs been considered?	Y	
	Are training needs included in the document?	Y	
7.	**Implementation and monitoring**		
	Does the document identify how it will be implemented and monitored?	Y	

	Title of document being reviewed:	Yes/No/ Not applicable	Comments
8.	**Equality analysis**		
	Has an equality analysis been completed for the document?	Y	
	Have Equality and Diversity reviewed and approved the equality analysis?	Y	
9.	**Approval**		
	Does the document identify which committee/group will approve it?	Y	
10.	**Publication**		
	Has the policy been reviewed for harm?	Y	
	Does the document identify whether it is private or public?	Y	
	If private, does the document identify which clause of the Freedom of Information Act 2000 applies?	NA	