Care Quality Commission

Monitoring the use of the Mental Capacity Act **Deprivation of Liberty Safeguards** in 2011/12

Summary

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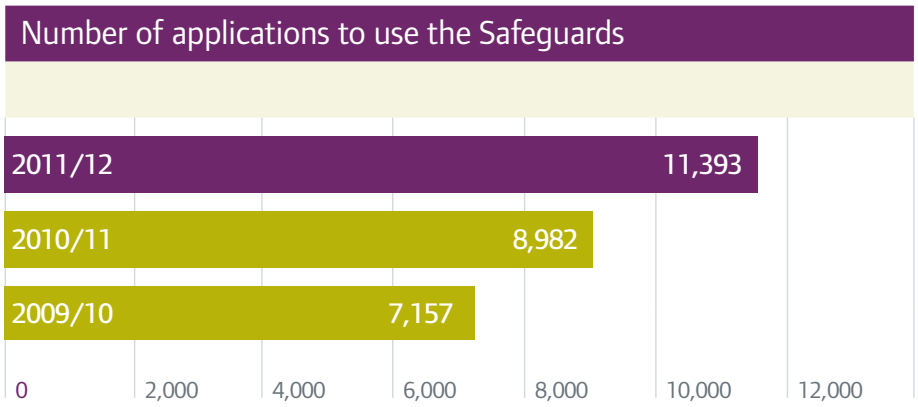
This is a summary of the Care Quality Commission's (CQC's) third annual report on the Deprivation of Liberty Safeguards ("the Safeguards").

Applications made

There has been a year-on-year increase in the number of applications to use the Safeguards since their first introduction

11,393
2011/12

+27%
on 2010/11



Regional rates

These ranged between 17 and 51 per 100,000 population. The average rate for England as a whole was

28
per 100,000

Purpose of the Safeguards

The Safeguards came into effect in 2009. They are part of a legal framework set out in the Mental Capacity Act 2005 (MCA). The MCA is a very important mechanism for protecting the rights of people who do not have the ability (mental capacity) to make certain decisions for themselves. It provides guidance to people who need to make decisions on behalf of someone else. It sets out the principles that should guide such decisions, including the need to act in the person's best interests and to achieve the desired outcome in ways that put the least restriction on the person's rights and freedom of action.

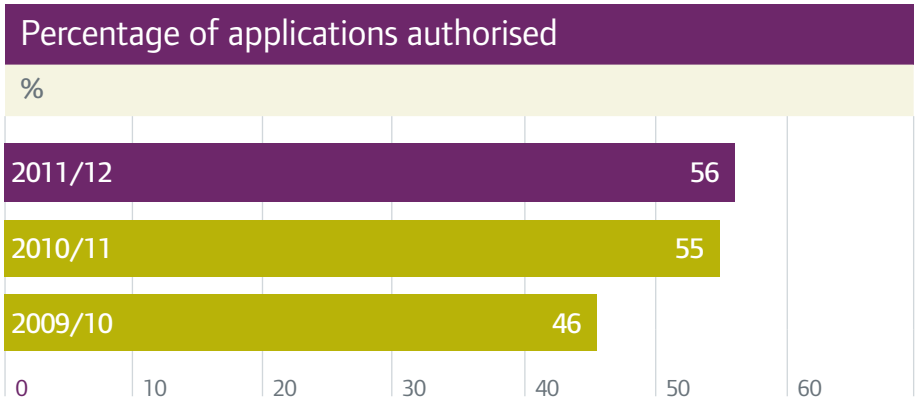
The Mental Capacity Act is primarily concerned with people who have mental disabilities. The Safeguards are particularly relevant for those with severe learning disabilities, dementia, or people who have brain injuries. The Mental Health Act focuses on people who have mental illnesses. In practice, the same person may be covered by both Acts, depending on individual circumstances.

Applications granted

There has been a year-on-year increase in the proportion of applications granted to use the Safeguards

56%
2011/12 **6,380**

+1%
on 2010/11



The reason the Safeguards were introduced was to address the problem that arises if a person does not have the mental capacity to make an informed decision about care or treatment. This problem was brought to light in the late 1990s by the case of Mr L and became known as 'the Bournewood Gap'. [1]

[1] HL v United Kingdom (2005) 40 EHRR 761

[2] Article 5(1) Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:… (e) the lawful detention… of persons of unsound mind…

The reason the Safeguards were introduced
The case of Mr L

Mr L was profoundly mentally disabled and unable to consent to medical treatment. He was admitted to hospital by a psychiatrist without the use of the Mental Health Act, as he was thought to be fully in agreement with this course of action.

His carers challenged this admission because of the restrictions on his liberty that were applied to him once in hospital and because Mr L did not have the capacity to disagree with the restrictions. The reality was that he was not free to leave.

The case went to the European Court of Human Rights, which agreed that Mr L had been deprived of his liberty within the meaning of Article 5 of the European Convention on Human Rights.[2]

The 'gap' that was identified was in the lack of safeguards for the admission and detention of people who appeared to agree but in fact lacked the capacity to consent or disagree.

There were no stated grounds for such action, no statement of purpose, no limits of time or treatment and no requirement for continuing clinical assessment. It was this gap that the Deprivation of Liberty Safeguards were designed to address.

There have been high profile failures in health and social care, which include deprivation of liberty. The Winterbourne View Serious Case Review highlighted the unlawful nature of restrictions imposed on people with learning disabilities in that service. It found that individual patient records gave rise to concerns because they did not accurately reflect the person's legal status under the Mental Health Act (MHA); nor did they give any indication as to whether the Safeguards had been considered.[3]

The decisions of the courts continue to develop mental capacity law, the meaning of 'deprivation of liberty' and practice. The health and social care system is currently changing. NHS primary care trusts will be abolished in April 2013, when local authorities will assume responsibilities as supervisory bodies for hospitals as well as for care homes.

How the Safeguards work in practice

The Safeguards must be considered in care homes and hospitals when the restrictions on a person's freedom, imposed in their best interests, may mean that they are deprived of their liberty. In addition to protecting the person's rights, the Safeguards can provide reassurance to staff that they are acting appropriately within the framework of the MCA, in a way that is proportionate to the risk of harm to the person. The two case studies, Mrs A and Mr B, illustrate this point.

[3] Winterbourne View Serious Case Review – p126 http://hosted.southglos.gov.uk/wv/report.pdf

CQC's role

CQC has a duty to monitor the operation of the Safeguards in England. A Code of Practice to the Safeguards sets expectations for CQC to monitor them through its existing programme of inspections, and to report annually.

Although CQC monitors the operation of the Safeguards, there are no enforcement powers associated with the role. If CQC finds that the Safeguards are not being used correctly, this could lead to action under the Health and Social Care Act. A number of the Health and Social Care Act regulations contain references to elements of the Safeguards – for example in the regulations dealing with consent, safeguarding, and general care and welfare.

CQC's findings

Use of the Safeguards is increasing. CQC's analysis of data from the NHS Information Centre shows that there were 11,393 applications to use the Safeguards in 2011/12, a 27% increase on the 8,982 applications made in 2010/11 and 59% higher than the 7,157 applications made in 2009/10, the first year of the Safeguards. More than half (56%) of all applications received resulted in authorisations being granted. This is similar to the 55% granted in 2010/11, but higher than the 46% granted in 2009/10.

So far there has consistently been significant regional variation among care homes and hospitals in the way the Safeguards are used. Application rates by region have varied over the first three years of the Safeguards' operation. In 2011/12, regional rates ranged between 17 and 51 per 100,000 population. The average rate for England as a whole was 28 per 100,000.

Case study
Mrs A, care home resident

Mrs A has severe dementia and lives in a care home. She makes persistent and purposeful attempts to leave the home.

Staff are concerned for her safety if she was to leave, but also concerned not to restrict her rights and freedom any more than the minimum necessary for her safety.

The care home (managing authority) decides to ask the local social services authority (supervisory body) to consider whether Mrs A should be 'detained' in the care home under the Deprivation of Liberty Safeguards.

The local authority carries out a series of independent assessments (looking at the person's best interests and medical needs and including the person's family) and notes that Mrs A's medication is not being administered correctly – which could be exacerbating her anxiety.

The assessor recommends that the GP should review the medication and look into an alternative medication plan. The local authority agrees to authorise deprivation of Mrs A's liberty for a short period to allow time for these aspects of the care plan to be changed.

Case study
Mr B, care home resident

Mr B has learning disabilities, with behavioural difficulties including aggression when frustrated or anxious. He was admitted as an emergency to a local residential care home, after a violent incident at home – connected both to his problems and to his mother's mental health issues and substance misuse.

The local residential home was unable to manage his behaviour, so he was placed in a specialist home 50 miles from his home. At this time he lacked capacity to consent to arrangements made by the home for his care.

He was missing his mum, who had been refused permission to visit, and made several attempts to leave the specialist home at bedtime before being brought back by staff in his pyjamas.

The home gave itself an urgent authorisation under the Safeguards to deprive Mr B of his liberty and requested a standard authorisation through the local social services authority. This request triggered a specialist assessment of Mr B's best interests.

The best interests assessor found the level of restriction to be disproportionate to the risk and seriousness of harm to Mr B. She decided that this deprivation of liberty could not be authorised as it stood.

She informed the commissioners of the service that a serious dispute between Mr B's mother and the unit should be mediated and, if unresolved, referred rapidly to the Court of Protection.

A formal best interests meeting was convened urgently. As part of this, contact between Mr B and his mother was reinstated, including facilitating visits from his mother to the care home. These visits were and are successful.

A care plan was agreed that worked towards moving Mr B into a supported living setting close to his mother's home and care staff are working to give him increased daily living skills.

Mr B is no longer deprived of his liberty, but looking forward to a more independent lifestyle.

Analysis of CQC's data from its monitoring activity shows that:

- **The umbrella legislation of the Mental Capacity Act (MCA) is not well understood or implemented in practice.** There is still a lack of understanding of the MCA among some staff in hospitals and care homes. If mental capacity is poorly understood, staff may be too quick to assume that people they are caring for lack capacity in respect of all decision-making (for example someone may lack capacity to make financial decisions but still be able to make decisions about their care or treatment). They may not look for ways to maximise people's capacity and decisions made on their behalf may not always be carried out within the best interests framework of the MCA. We know there have been instances where relatives and friends have been excluded from decision-making or asked to consent on behalf of the person in a way that is not lawful.

- **The implications of the Safeguards in practice are not easy to understand.** The Safeguards have only been in operation for three years, and so are still relatively new. In previous reports CQC has noted concerns about the complexity of the systems surrounding the Safeguards. This continued in CQC's inspection visits in 2011/12. There was also evidence that, on some mental health hospital wards, staff still did not understand the differences between the powers of the MHA and the Safeguards and how to decide which legislation is the appropriate one to use. This has implications for the way they are used, authorised and monitored and affects all parts of the system including hospitals, care homes, local authorities, primary care trusts and CQC. It may mean that people in hospitals and care homes are still not always treated or cared for in ways that respect their human rights – especially the right to liberty.
- **The use of restraint is not always recognised or recorded as such, and because of this it is not easy to monitor**. CQC is concerned that people's freedom sometimes appears to have been restricted without consideration of their capacity to consent to, or refuse, the restriction being recorded. Some examples showed little or no evidence of any attempt to maximise a person's decision-making capacity before resorting to restriction or restraint. The use of the phrase 'best interests' does not always appear to signal that there has been a process of best interests decision-making in accordance with the MCA.

  Restraint is sometimes not recorded adequately, or not governed by policies to minimise its use. It can become routine, without ongoing consideration of less restrictive alternatives. For example, some inspection reports contained information about the use of restraint equipment, including 'wander mats' or 'sensor mats' – devices that alert staff when an individual gets out of bed. A number of these showed there was no evidence of appropriate capacity assessments or authorisation for the use of these.
- **There is wide variation in how local authorities carry out their functions as supervisory bodies.** Supervisory bodies hold both key decision-making (authorisation) and assurance roles in the Deprivation of Liberty Safeguards system. Because of the key role they play in this system, CQC identified a priority to improve access to information on how supervisory bodies carry out their responsibilities under the Safeguards. This thinking has been developed in consultation with external stakeholders. In 2012 CQC piloted a questionnaire among some supervisory bodies, asking about functions above and beyond those reported in the NHS Information Centre data. The pilot gave us useful insight into the variations in how supervisory bodies work and information on which to build our monitoring of supervisory bodies' function in the future. This will focus on understanding the reasons for the variations.

We have seen examples of good practice in relation to best interests meetings, and instances where staff strived to listen actively to people using services and to involve them in decision-making

- **It is not clear whether people's views and experiences of the Safeguards are being heard in care homes and hospitals.** In some services, there is evidence that people's experiences and opinions of the Safeguards in practice are sought and acted on, as well as those of their relatives and advocates. We have seen examples of good practice in relation to best interests meetings, and instances where staff strived to listen actively to people using services and to involve them in decision-making. This included using non-verbal communication and watching reactions to situations.

  However, there was very little evidence in CQC's inspections of the involvement of people who use services and their relatives or friends in the processes of the Safeguards themselves. This is a significant omission: consultation with the 'relevant person' and their relatives and/or close friends interested in their welfare is a mandatory part of the assessment process.

  CQC has a statutory duty under the Health and Social Care Act 2008 to listen to and consider the views expressed by people and carers. CQC piloted an approach to engaging people with experience of the Safeguards in 2011/12. In 2013 we will look at the outcomes of this project, in discussion with people who use services, and develop ideas on how to help take the work forward.

The Safeguards cannot be understood without reference to the guidance on good practice that is to be found throughout the MCA. The highest priority, therefore, for health and social care in operating the Deprivation of Liberty Safeguards system is to improve understanding and practice of the Mental Capacity Act

Conclusions and next steps

The MCA is a very important mechanism for protecting the rights of people who do not have the ability (mental capacity) to make certain decisions for themselves. There continues to be confusion around the precise definition and thresholds for deprivation (as opposed to restriction) of liberty. Recent court cases have ruled that there is no universal definition. Decisions can only be made on individual circumstances. The relationship between care, appropriate restrictions of liberty, the Deprivation of Liberty Safeguards and the wider MCA has become complex and potentially confusing.

The Safeguards cannot be understood without reference to the guidance on good practice that is to be found throughout the MCA. The highest priority, therefore, for health and social care providers in operating the Deprivation of Liberty Safeguards system is to improve understanding and practice of the MCA. This is also true for CQC both in its role as regulator and in monitoring the use of the Safeguards. CQC recognises that ongoing improvements in its monitoring of the Safeguards, and the wider MCA, are vital tools to protect and promote the human rights of vulnerable people in health and social care.

CQC expects the following:

- **Providers and commissioners of services for vulnerable adults must improve their understanding of the Mental Capacity Act and the Safeguards.** Training in the MCA and the Safeguards is still patchy and not always reflected in improvements in practice. The use of care plans, recording of incidents and gathering of feedback from staff, people who use services and their relatives all need to improve. Such practice needs to show that it complies with the principles of the MCA, and to demonstrate an understanding of when and how to explore a person's capacity to make a specific decision, and of best interests decision-making. Stronger links between managing authorities and local Independent Mental Capacity Advocate services may be one way of improving staff knowledge.
- **Care providers must implement policies that minimise the use of restraint.** Restraint should always be a 'last option'. Encouraging positive behaviours, with a view to minimising the use of restraint, can be explored in forums such as team meetings. CQC expects to find a greater understanding of the best interests and least restriction principles in the MCA and of the practice implications of the MCA's provisions on restraint. Staff need to be aware of when lawful restraint might be moving into a deprivation of liberty that requires specific authorisation.
- **Providers and commissioners of services must establish robust review processes and other mechanisms for understanding the experience of people subject to the Safeguards.** CQC's inspectors saw examples of friends and relatives being excluded from best interests decision-making, contrary to the requirements of the law. Providers and commissioners must go to greater lengths to consult with relatives and friends as part of the process when using the Safeguards.

What CQC will do next

In line with its proposed strategic direction over the next three years, CQC intends to strengthen how it meets its responsibilities on mental health and mental capacity. Key to this will be making more use of CQC's unique sources of information, alongside better analysis of national data sets and strengthening how it works with its strategic partners. Consultation with the public and stakeholders has indicated stron g support for this.

CQC will:

- **Improve inspectors' understanding of the Mental Capacity Act and the Safeguards.** We will continue the roll-out of training and resources for our staff on mental capacity and the Safeguards. We will work with stakeholders to make sure our guidance for providers and for CQC staff is up to date and reflects relevant case law.
- **Develop its work with local authorities in their role as supervisory bodies**. We intend to develop our methodology for gathering information on the operation of the Safeguards system from local authorities in the coming year. However, the success of this initiative as a monitoring tool will depend to a significant extent on the willingness of local authorities to collaborate with CQC. The shared objective must be ensuring that the Safeguards operate to maximum effect for the protection of vulnerable adults in health and social care settings.
- **Further develop ways to gather the experiences of people lacking capacity and their friends, families and carers.** We will carry out a new pilot study involving people's representatives and Independent Mental Capacity Advocates. This will help increase CQC's understanding of the experiences of people while they are subject to the Safeguards and help better understand the quality of service.
- **Continue to promote evidence of what works well.** We will highlight best practice and work to communicate this information to providers, staff and other stakeholders.

The shared objective must be ensuring that the Safeguards operate to maximum effect for the protection of vulnerable adults in health and social care settings

Main cover image and the image appearing on page 2 www.careimages.com

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