

The operation of the
Deprivation of Liberty Safeguards
in England, 2009/10

March 2011

Contents

Introduction	2
Key findings	2
1. Background	4
2. The Safeguards in context	6
3. Our findings: Supervisory bodies	8
4. Our findings: Managing authorities	10
5. Developing our monitoring role	14
6. Conclusions and key issues	15
References	17

Introduction

The Mental Capacity Act Deprivation of Liberty Safeguards came into force on 1 April 2009. The Safeguards provide a legal framework for hospitals and care homes to obtain a power to lawfully deprive people who are using their services of their liberty. This applies when they lack capacity to consent to their care or treatment. The safeguards aim to protect some of the most vulnerable people in our society.

The Care Quality Commission (CQC) has a duty to monitor the application of the Deprivation of Liberty Safeguards. This monitoring role covers hospitals and care homes as managing authorities and primary care trusts (PCTs) and councils as supervisory bodies.

This is our first report on the Safeguards and provides an overview of how they were implemented and used in their first year (2009/10).

The first year of CQC (2009/10) was a year of transition and our regulatory systems have been evolving as we moved from the Care Standards Act 2000 and the Health and Social Care (Community Health and Standards) Act 2003 towards a new system of regulation under the Health and Social Care Act 2008. From April 2010 onwards, the Health and Social Care Act has brought all providers of adult social care and health care into the same system of regulation.

This transition period meant that there were separate regulatory regimes, which are reflected in this report through the different methodologies used for monitoring the Deprivation of Liberty Safeguards across the different sectors.

Key findings of this report

What is working well?

- Some hospitals and care homes are demonstrating good practice in using the Safeguards to protect people's rights, and have made some good progress in ensuring that their staff are aware of their duty under the Safeguards.
- Many PCTs and councils made good progress in the first year in implementing the mechanisms set out in the Safeguards. Some have been proactive in ensuring that that the hospitals and care homes in their area are active in the Safeguards process.
- Many PCTs and councils have worked effectively together, and established joint teams to fulfil their supervisory body role.

What is not working well?

- There was a clear variation in organisations' understanding and practice of the Safeguards and in staff training. We came across too many examples of managers and staff in hospitals and care homes who were unaware of the Safeguards or who had received no training on them, even towards the end of 2009/10.

- We saw too many examples of staff in hospitals and care homes using restraint or restricting people's movement where they failed to consider that these practices could deprive a person of their liberty.

Issues raised in this report

- Managing authorities, supervisory bodies and key stakeholders have called for clearer guidance as to what may constitute a 'deprivation of liberty'. Our findings have highlighted uncertainty among staff in some managing authorities about when the Safeguards should be used. We recommend that the Department of Health consider developing clear and concise briefings that are accessible and easily applied to practice.
- While it may be helpful to have a clear definition of a deprivation of liberty, health and social care staff should be trained effectively to be aware of the types of practice that could mean people using their services are deprived of their liberty. If there is any uncertainty, they can seek advice from their supervisory body.
- Our first year of monitoring was done under separate regulatory regimes. Now that our new regulatory framework under the Health and Social Care Act 2008 is in place, we are in a position to develop our monitoring role to be more consistent across health and adult social care.
- There have been criticisms of the Safeguards for being over-bureaucratic, and for the amount of paperwork that is needed to make assessments and comply with the legal requirements. The evidence we have gathered during our first year of monitoring has been necessarily limited, and this has not given us any significant insight into this issue. However, we encourage the Department of Health to consider whether it may be possible to reduce the amount of paperwork needed to use the Safeguards.

1. Background

The Deprivation of Liberty Safeguards, introduced in 2009, provide a legal framework to ensure that people are deprived of their liberty only when there is no other way to care for them or safely provide treatment and ensure that, when this is necessary, people's human rights are protected. They can be used for adults over the age of 18 years who are in hospitals or care homes. People who may need the additional protection offered by the Safeguards include those with severe learning disabilities, older people suffering from the range of dementias, and people with neurological conditions such as brain injuries.

For the purposes of the Mental Capacity Act, a hospital is "any institution for the reception and treatment of persons suffering from illness, any maternity home, and any institution for the reception of persons during convalescence or persons requiring medical rehabilitation, and includes clinics, dispensaries and out-patient departments maintained in connection with any such home or institution."

Similarly, a care home "provides accommodation, together with nursing or personal care, for people who are or have been ill, have or have had a mental disorder, are disabled or infirm, are or have been dependent on alcohol or drugs".

The hospital or care home (the managing authority) must apply to the PCT or council (the supervisory body) for authorisation to deprive a person of their liberty. The supervisory body must then decide if the application is appropriate. If it is, they must then carry out a series of assessments to determine whether a deprivation is legal, including a test of whether it is in the person's best interests.

The Safeguards cannot be used in certain situations where the person concerned is subject to detention or other compulsory measures under the Mental Health Act 1983. Nor can they be used to detain a person in hospital for treatment for mental disorder, if they meet the criteria for detention under the Mental Health Act, and are objecting to the admission or treatment (unless someone authorised to do so consents on the person's behalf).*

To comply with Article 5(4) of the European Convention on Human Rights, both the person in question and their representative have the right to appeal to the Court of Protection against a decision to deprive them of their liberty or to change any conditions imposed as part of the deprivation of liberty. Advance decisions made by the relevant person must be respected and all professionals involved are personally liable for their decisions.

* In 2009 the Court of Protection handed down its first rulings interpreting the relationship of the Deprivation of Liberty Safeguards to the Mental Health Act's powers of detention. One case centred on which statutory regime was appropriate for the detention of GJ, a patient with dementia and physical disorders who was objecting to his placement in hospital. The Court recognised and upheld what it called the 'primacy' of the Mental Health Act in situations where patients met the criteria for detention under its powers and were objecting to treatment or admission.

What does it mean to be deprived of liberty?

A deprivation of liberty is defined by Article 5 (1) of the European Convention on Human Rights. However, there is no single definition or any checklist that can be used to automatically identify in which circumstances a person is being deprived of their liberty.

In 2008, the government published a Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice. Both Codes have statutory force. Paragraph 2.3 of the 2008 Code states that:

“The difference between deprivation of liberty and restriction upon liberty is one of degree or intensity. It may therefore be helpful to envisage a scale, which moves from ‘restraint’ or ‘restriction’ to a deprivation of ‘liberty’. Where an individual is on this scale will depend on the concrete circumstances of the individual and this may change over time.”¹

A single decision or occasional restrictions to a person's freedom are unlikely to mean that they are being deprived of their liberty.

A number of cases concerning deprivation of liberty have come before the European Court of Human Rights and the UK courts. The following list is based on the judgements of several of these cases and indicates the circumstances that have led to courts deciding that patients **have** been deprived of their liberty:²

- Restraint was used to admit a person to a hospital or care home when they were resisting admission.
- Medication was given forcibly, against a patient's will.
- Staff exercised complete control over a person's care and movements.
- Staff made all decisions on a person's behalf, including choices relating to assessments, treatment, visitors and where they could live.
- Hospital or care home staff took responsibility for deciding if a person could be released into the care of others or allowed to live elsewhere.
- When carers requested that a person be discharged into their care, hospital, or care home staff refused.
- A person was prevented from seeing friends or family because the hospital or care home restricted access to them.
- A person was unable to make choices about what they wanted to do and how they wanted to live, because hospital or care home staff exercised continuous supervision and control over them.

People are entitled to be cared for in the least restrictive way possible, and care planning should always consider if there are other, less restrictive options available to avoid an unnecessary deprivation of liberty. In some cases, it may be necessary to deprive someone of their liberty.

2. The Safeguards in context

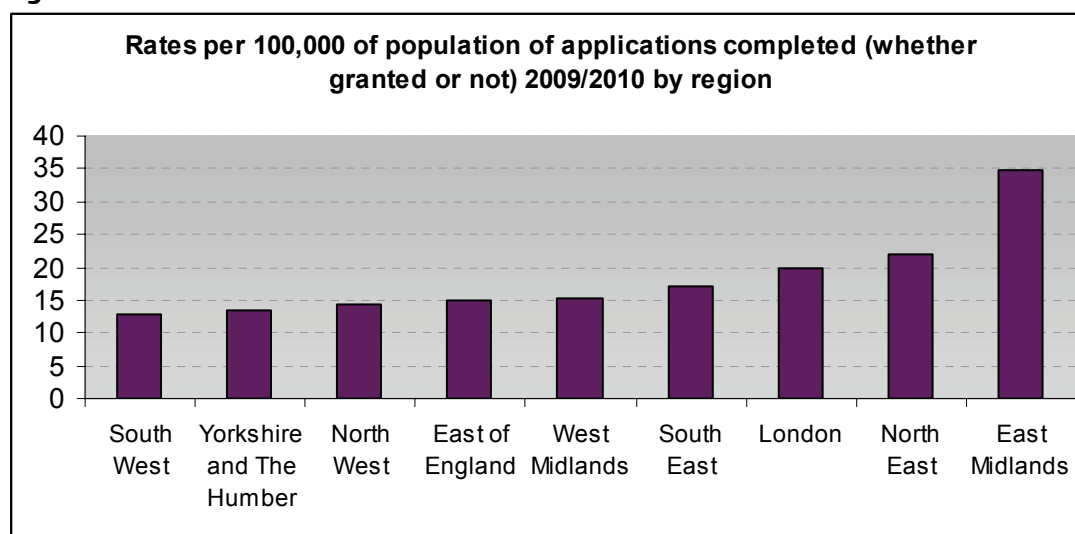
The Information Centre for health and social care collected and summarised information provided by PCTs and local authorities.³ This highlights several key trends in 2009/10.

There was a much lower than expected total number of applications to obtain authorisation to deprive someone of their liberty (7,160 in England compared with the 21,000 that was predicted for England and Wales). One explanation is that a higher than predicted proportion of assessments ended in an authorisation, suggesting that fewer 'unnecessary' assessments were applied for.

As expected, the majority of applications were made to local authorities from care homes (75%) rather than from hospitals to PCTs. The largest proportion of applications were for a person who lacked capacity because of dementia. Physical disability, frailty and/or temporary illness was the next largest distinct group, followed by learning disability.

There were also significant regional variations in the rate of applications (figure 1). The highest rate was in the East Midlands, which received 17% of all applications (35 per 100,000 population). For five of the nine regions, the rate of application was less than half this.

Figure 1:



These differences are probably due to local practice in implementing the Safeguards. Five PCTs and three local authorities did not receive any applications and this raises questions about awareness and understanding of the Safeguards in these areas.

More than half the applications in this first year were not authorised. About 4.3% of applications that were not authorised involved situations where the person was nevertheless judged as being cared for in a way that amounted to a deprivation of liberty. In these cases, hospitals and care homes may be acting illegally if that person was not swiftly cared for or treated in a less restrictive way.

PCTs rejected a larger proportion of applications than councils on the grounds that the Eligibility Assessment was not met. In these situations, the Mental Health Act may have been a more appropriate instrument and it is possible that some of these people were subsequently detained in hospital under the Mental Health Act.

The number of people subject to a standard deprivation of liberty authorisation at the end of 2009/10 was more than double the number at the end of the first quarter of that period, and this number has risen steadily in subsequent quarters. During the first two quarters in 2010/11, there was a 28% increase in the number of assessments carried out against the same six months of 2009/10.

In July 2010, the Mental Health Alliance published *Deprivation of Liberty Safeguards: an initial review of implementation*.⁴ This highlighted some positive achievements in the first year of the implementation and reported widespread support for the principles of the Safeguards. However, it also identified a number of emerging concerns and, although the aims of the Safeguards were universally supported, there was a consensus that many of those aims had been only partially achieved.

The report acknowledged that training and raising awareness before implementation had led to care practices being revised and unnecessary restrictions on liberty removed. However, it also found that the introduction of the Safeguards has revealed a widespread lack of understanding of the main Mental Capacity Act. Care providers do not know when they are exceeding the powers it gives them, and therefore cannot know when they need to apply for an authorisation to deprive a person of their liberty.

3. Our findings: Supervisory bodies

Key points

- Most PCTs and councils have made good progress in implementing the mechanisms and processes for the Safeguards. However, some PCTs were still at the early stages of implementation more than a year after the Safeguards were introduced, which is not acceptable.
- Several local areas had joint and/or co-funded teams to deal with the Safeguards, demonstrating efficient and effective joint working between PCTs and councils.
- A common feature of supervisory bodies was for Deprivation of Liberty Safeguards teams to be based in safeguarding teams. While this may appear sensible, the two issues are different, and services must balance the need to protect a service user with the need to empower them and protect their rights.

We monitored the mechanisms that PCTs and councils had put in place to make authorisations during 2009/10. We asked about the following issues:

- What mechanisms the organisations had put in place to make authorisations.
- How they were dealing with the expectations now being placed on them.
- The consistency of the threshold that assessors appeared to be applying when determining whether there was or wasn't a deprivation of liberty.
- What arrangements were in place in their area to support the professional development of those acting as assessors.

We gathered the information at different times. We collected most information from councils between April and August 2009, and from PCTs between September 2009 and June 2010. Around 60% of councils gave us sufficient detail for us to be confident in giving an indication of their current practice, but only 67 PCTs, slightly under half of all English PCTs gave us sufficient detail. We analysed the submissions from both councils and PCTs and grouped each one into four stages of implementation:

- **Comprehensive** – it had fully implemented all aspects of its role and had routinely begun to evaluate its practice. Staff were trained. Best Interests Assessors were appointed and well supported.
- **Solid** – it was working effectively in its role. Staff were trained. A team of Best Interests Assessors was beginning to work effectively and consistently.
- **Partial** – it had implemented the mechanisms to operate as a supervisory body. It had developed policies and a training programme.
- **Early** – it was in the process of setting up the mechanisms needed to operate as a supervisory body. A training programme had started but actual dealing with applications was at an early stage.

As the information for PCTs and councils was collected at different times, we need to look at the dispersal for the different organisations separately:

	Councils (data collected April-Aug 2009)	PCTs (data collected Sept 2009-June 2010)
Comprehensive	14%	37%
Solid	21%	45%
Partial	31%	10%
Early	33%	8%

Most PCTs and councils that provided sufficient information for us to make a judgement had made good progress in implementing the Safeguards. However, it is poor that, even at the end of the year, five PCTs were judged to be at an early stage of implementing the mechanisms for the Safeguards.

The information we have is partial. For PCTs in particular, this may be because this information was collected outside our usual regulatory work. Some organisations said that these requests for information were an additional burden for them. Nevertheless, it is concerning that the majority of PCTs provided limited or no information, which may indicate that these organisations did not have the necessary information available to answer the key questions.

Throughout 2009/10, there was a rise in the number of people subject to a standard deprivation of liberty authorisation, and this rise continued into 2010/2011. This certainly indicates that, as the Safeguards have become more embedded into practice, the number of applications to deprive someone of their liberty has increased. It also suggests that, where no applications have been made, implementation has been slow.

The Information Centre’s data collection revealed that five PCTs and three councils did not receive any applications at all during the year. Of these eight supervisory bodies, five did not submit any information to CQC as part of our data collection. Of the three that did submit information to us, two were found to be at the early stage of implementation: one was a council and one was a PCT.

We saw a trend of councils and PCTs establishing joint teams to implement the Safeguards and put them into practice, showing that local organisations are working well together to ensure that care is consistent.

One recurring feature was the establishment of Deprivation of Liberty Safeguards teams within safeguarding teams. While this may appear sensible, it also raises some concerns. These designated teams may be considering the Deprivation of Liberty Safeguards as an extension of the safeguarding role, potentially leading to staff not being mindful of the requirement for the least restrictive practice. Furthermore, staff may also be unaware that it is inappropriate for someone to be deprived of their liberty as part of a safeguarding plan unless they are also subject to Deprivation of Liberty Safeguards assessments and authorisation. In recent case law a person (known as E) was unlawfully deprived of his liberty by the local authority, which had placed him in respite care in response to safeguarding concerns. The local authority had failed to authorise the deprivation of liberty using the Safeguards and the deprivation was therefore unlawful.⁵

4. Our findings: Managing authorities

Key points

- Our inspections have highlighted a lack of understanding of both the Safeguards and the wider Mental Capacity Act in some areas.
- Managing authorities have demonstrated some good progress in ensuring that their staff are aware of the Safeguards. But progress is variable. We came across too many examples, even towards the end of the year, of managers and staff who were not aware of the Safeguards or had received no training on them.
- We came across too many examples of managing authorities using restraint or restricting people's movement where they failed to take into consideration that this may deprive a person of their liberty.
- Some staff in acute mental health units for patients detained under the Mental Health Act do not have enough awareness about the Safeguards and the implications for any informal patients.

We monitored how managing authorities apply the Safeguards using our regular inspection processes in 2009/10.

Inspections of care homes

Our staff made around 15,000 visits to adult care homes in England between April 2009 and March 2010. We analysed a sample of the inspection reports from these visits. One of the key findings of the data from the Information Centre was the variation in the number and rate of applications made across England. We therefore analysed the 3,327 inspections we carried out in the East Midlands (which had the highest rate of applications) and the South West (which had the lowest).

Staff training and awareness

To comply with the legislation, care homes must ensure that their staff understand the Safeguards and that they are aware of when they may need to use them. In many inspections reports we analysed at least some, and sometimes all, staff had received some training on the Mental Capacity Act and the Safeguards.

However, we came across some instances where members of staff were unaware of the Safeguards and the implications for their services, and some where even care home managers demonstrated a clear lack of understanding about the Safeguards.

Almost a third (29%) of those inspection reports that referred to training in the Safeguards reported that either no staff were trained or that training had not yet taken place, but was planned for the future. This may be understandable at the beginning of 2009/10, but as the year progressed, it demonstrates poor practice in care homes as staff may be providing services in a way that may contravene the Human Rights Act without them being adequately equipped to recognise this.

Although the number of care homes with no staff trained in the Safeguards did decrease during 2009/10, 13 of the inspection reports in our sample showed that care homes had not provided any staff with training on the Safeguards in Q4 2009/10. This may be a small number, but taking into consideration the size of the sample and what this might mean for care homes across the country, this is a concerning finding.

Use of restraint

The sample of inspection reports highlighted several examples where some form of restraint was being used. Restraint is the use of force (or the threat of using force) to make someone do something they are resisting, or when someone's freedom of movement is restricted, whether they are resisting or not. Restraint can be appropriate when used from time to time to prevent harm to a person who lacks capacity and if it is a proportionate response to the likelihood and seriousness of the harm. When using forms of restraint, it must always be considered whether the extent of this restraint means that the person is being deprived of their liberty.

The Code of Practice states that "the distinction between a deprivation of, and restriction upon, liberty, is merely one of degree or intensity and not one of nature or substance" and there are some circumstances in which the use of restraint may develop into a deprivation of liberty. The Code also states that: "Where the restriction or restraint is frequent, cumulative and ongoing, or if there are other factors present, then care providers should consider whether this has gone beyond permissible restraint, as defined in the Mental Capacity Act and whether or not, this may be a deprivation of liberty."⁶

We found that several homes had restraint policies that had not been updated to reflect the Mental Capacity Act or the Deprivation of Liberty Safeguards. This is not acceptable.

We found several examples of restraint being used, but where staff failed to consider in which circumstances the use of restraint may become a deprivation of liberty. Several care homes restricted the movement of service users around the home and this can also be viewed as a form of restraint. Although this may be appropriate in some circumstances, it was sometimes done without consideration of the Mental Capacity Act or any consideration that this practice may be amounting to a deprivation of liberty for some people.

For example, during an inspection following a safeguarding alert, we found that a person in the care home who often suffered from confusion as a result of dementia was being locked in a room alone overnight and not checked by staff for periods of up to 10 hours. This person's notes described their usual routine as being up at night and up early in the morning. However, because of their confusion and lack of mental capacity, they would be unable to use the call bell to summon assistance if necessary, and were therefore unable to follow their desired and usual routine. This practice was being carried out without any consideration that it may have been a deprivation of the person's liberty. There was also no apparent consideration of any less restrictive practice and no thought given to alternatives such as increasing the number of staff overnight.

Our staff raised this issue and we required the care home manager to attend training in the Mental Capacity Act and Deprivation of Liberty Safeguards, so that we could be confident that she understood her responsibilities in situations that may require the Safeguards to be used. By our next inspection in December 2009, there had been significant improvements in the care provided in the home and the manager had completed her training.

Some care homes restricted residents' access by locking doors or having doors with keypads. While this may be necessary to prevent some people from being harmed, the care home also needs to follow the Deprivation of Liberty Code of Practice if the restrictions amount to a deprivation of liberty. In one case, due to one person's really complex needs that have directly impacted on the other residents, a decision had been made to provide the person with care in a small flatlette in the home. We told the acting manager that this may be considered a deprivation of a person's liberty and an assessment was needed.

In some instances, the use of restraint may be subtle. While inspecting one care home, one of our inspectors came across a service user who was being nursed in bed due to a very long delay in the home obtaining an appropriate specialist chair. Although this practice may not be a deliberate restriction, the home still needed to bear in mind that the outcome for that person was the same, and that this may have been a deprivation of their liberty.

Although these examples are infrequent in the sample of inspection reports, they do raise some concerns – particularly if practice in these regions is representative of practice across the country. In some cases, our inspectors considered that care was being provided in such a way that deprived a person of their liberty without there being any evidence of consideration of the Mental Capacity Act and the Safeguards. This is not acceptable and shows the uncertainty and a lack of understanding among staff in managing authorities as to the meaning of the legislation and how it impacts on the care they provide.

In some instances, it also implies a misunderstanding of the wider Mental Capacity Act when using, or considering using, restraint – in that care providers do not know when they are exceeding the powers it gives them and therefore cannot know when they need to apply for an authorisation to deprive a person of their liberty.

Visits to hospitals by our Mental Health Act Commissioners

Our Mental Health Act Commissioners visit all hospital wards where patients are detained under the Mental Health Act 1983. The aim of their work is to meet detained patients to discuss their experiences and concerns, make sure that they understand their rights, and check that staff are using the Mental Health Act correctly. In some instances, our Commissioners also reported on the use of the Deprivation of Liberty Safeguards.

Where they reported on the Safeguards, our Commissioners uncovered similar variations in the level of awareness and training among staff to those found in our inspections of care homes. In some instances, all staff were trained and fully aware of their responsibilities; in others, staff had no training and demonstrated a lack of understanding.

We have seen a continuing year-on-year rise in the proportion of locked acute wards. During 2009/10, three-quarters of acute wards visited were locked.⁷ Many locked wards have no official designation as 'secure units', and provide care to informal patients as well as those detained under the Mental Health Act. On some visits, we found that informal patients in

these units were not free to leave and locked doors or keypads were used to restrict entry and exit to and from the units for all patients.

This raises concerns that some informal patients in such facilities are at risk of 'de facto' detention, or a deprivation of liberty without legal authority, and this is not acceptable practice. To ensure that the rights of informal patients on these units are protected, all staff in these units must be trained appropriately to ensure that they are aware of the Mental Capacity Act and the Deprivation of Liberty Safeguards and the impact of these on the care they provide.

The findings from our Mental Health Act monitoring visits show that, in some mental health units, there is a lack of awareness of the Safeguards and their impact on informal patients in these units, particularly those that are locked.

Lack of understanding of the Safeguards

An overriding feature of the findings from all of our inspection work is an uncertainty as to what it means for a person to be deprived of their liberty. As mentioned earlier, there is no legal definition of the circumstances that may constitute a deprivation of liberty and the examples we found demonstrate the lack of understanding among staff in managing authorities.

This is particularly noticeable around key issues such as restraint and the restriction of movement. There is also a lack of understanding that a number of restrictions of liberty combined may become equivalent to an actual deprivation of liberty. Tangible and clear cut restrictions such as locked doors are sometimes not even considered in the sense that they may in themselves tip the balance from a restriction of liberty to a deprivation of liberty. When any restriction is imposed, care home staff should always consider the Safeguards and whether they are relevant for any people using the service who are affected by this restriction.

One area of confusion, seen in a small number of inspection reports, was the misunderstanding that if a managing authority deprived a person of their liberty and this was in the person's best interests, then they would not need to apply for authorisation from their supervisory body. This is definitely not the case and was identified as an "especially common misunderstanding" in the Mental Health Alliance report.⁸

Our inspections of managing authorities also highlight some confusion over the wider Mental Capacity Act. Care providers may not know when they are exceeding the powers it gives them and therefore may not know when they need to apply for an authorisation to deprive a person of their liberty. Indeed, some inspection reports showed that some care homes were failing to carry out any assessments of mental capacity on any service users.

5. Developing our monitoring role

The introduction of the Deprivation of Liberty Safeguards coincided with our first year as the independent regulator of health and adult social care. During this year, we worked within different regulatory frameworks for the different sectors affected by the Safeguards. As a result, our monitoring of the Safeguards within adult social care was different to that across the NHS and in mental health units.

Providers have now been brought into the same system of regulation under the Health and Social Care Act 2008. The cornerstone of this new regulatory regime is the new system of registration and monitoring of providers' compliance with essential standards of quality and safety.

This new system is focused on outcomes for people rather than on systems, processes and policies, and puts the views and experiences of people who use services at its heart. As part of this new, more responsive and dynamic system, we will continually review all the information we have about a provider to monitor its compliance and, where necessary, use our enforcement powers to ensure that it meets the essential standards of quality and safety.

This includes enforcing important requirements that ensure people's rights are respected and that their needs are properly assessed, thoroughly planned for and regularly reviewed. For example, if we have concerns about the use of restraint and people's capacity to consent, we can consider whether regulation 11 (outcome 7 of the essential standards – 'Safeguarding people who use services from abuse') is being met.

The analysis for this report highlighted some regional differences in the way care homes were inspected against the Safeguards. A higher proportion of inspection reports from the South West region recorded information on the Safeguards than those from the East Midlands. This difference is initially surprising since the East Midlands had the highest rate of applications for a Deprivation of Liberty in the country, with the South West having the lowest rate (see Figure 1). It is difficult to come to any conclusions as to the cause of this difference between the two regions but it may be that our monitoring role in 2009/10 relied on the knowledge and awareness of our inspectors and assessors of the Safeguards and how they work in practice.

This report also revealed some uncertainty among our own staff, as well as among care home staff, as to which circumstances may require a managing authority to apply to deprive someone of their liberty.

We have already begun to explore these issues further and are working to ensure that we minimise any regional differences in our operational work. All our inspectors were trained in the Safeguards early in 2009. However, this report presents another opportunity to raise awareness of our role in monitoring the Safeguards and to improve the vigilance and understanding of our role among our inspectors, assessors and Mental Health Act Commissioners.

6. Conclusions and key issues

A key message from our findings across health and adult social care is the variation between different organisations in practice, understanding and training.

We came across too many examples of people using services who were being cared for in ways that potentially amounted to an unlawful deprivation of their liberty, and therefore potentially a breach of their human rights. In most cases, this was because services imposed significant restrictions of liberty without any consideration of the Safeguards. We expect that as training and awareness of the Safeguards improves, there will be fewer such examples of poor care.

In addition to further training, there needs to be more understanding around the circumstances that may amount to a deprivation of liberty and of the types of cases that should have gone to the Court of Protection. We acknowledge the difficulty in understanding exactly which circumstances amount to a deprivation of liberty and in keeping pace with legal judgements from the Court of Protection that continually refine and add to the body of knowledge around what constitutes a deprivation of liberty. The Department of Health has issued several briefings to aid understanding of what constitutes a deprivation of liberty,^{9, 10} but future briefings could be more frequent and be written in a way that is accessible and more easily applied to practice.

However, the lack of a definition should not be used as an excuse for staff to be unaware of the types of practice that should lead them to consider that people using their services may be deprived of their liberty. Staff in managing authorities should also be able to obtain advice and support from their supervisory body when considering if restrictions to a person's liberty are equivalent to a deprivation.

Managing authorities, supervisory bodies and key stakeholders have criticised the Safeguards for being over-bureaucratic and for the amount of paperwork needed to make assessments and comply with the legal requirements. Although we do not have substantive evidence of this, it may have influenced the lower than expected rate of applications to deprive a person of their liberty. If the processes to do so are expensive and time-consuming, it is possible that managing authorities and supervisory bodies are either changing their practice to ensure that they do not deprive people of their liberty, or worryingly, they may not be adhering to the Deprivation of Liberty Safeguards.

We also found a lack of understanding of the wider Mental Capacity Act. As the Safeguards are relatively new and only recently implemented, some misunderstanding and lack of awareness might be expected. However, the wider Mental Capacity Act is more established and a lack of understanding about its basic principles is unacceptable.

Recommendations for improvement

The Department of Health

Consider developing clear and concise briefings that are regularly updated and circulated to all bodies involved in the Deprivation of Liberty Safeguards. These briefings must be explicit about the implications of the case law for practice and be written in a way that is accessible and more easily applied to practice than previous briefings.

All organisations with a role to play in the Deprivation of Liberty Safeguards

Ensure that relevant staff are effectively trained in the Deprivation of Liberty Safeguards and that they understand the requirements placed upon them by the Safeguards.

Ensure that all staff fully understand the requirements of the wider Mental Capacity Act to ensure that people using services have their rights protected and supported.

Supervisory bodies

Give careful consideration to how they are fulfilling their role as a supervisory body in key areas such as their capacity to conduct assessments and to ensure consistency in the outcomes of applications to deprive a person of their liberty.

Ensure that those managing authorities from which they commission care are fully aware of their responsibilities under the Deprivation of Liberty Safeguards and consider whether they have been proactive enough in promoting and supporting understanding within managing authorities of the Safeguards.

Managing authorities

Ensure that all staff are fully aware that they should be using the least restrictive methods to care for people using services. People should only be deprived of their liberty if it is in their best interests and if it is essential to ensure that they do not come to harm.

Managers working in mental health units

Ensure that all staff in these units are aware that imposing restrictions of movement on **all** patients may be a deprivation of liberty for informal patients. This will ensure that the way they care for informal patients does not amount to a deprivation of liberty without legal authority.

References

1. Department of Health, *The Mental Capacity Act 2005: Deprivation of liberty safeguards - Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice*, August 2008.
2. Department of Health, *Deprivation of Liberty Safeguards: A Guide for hospitals and care homes*, February 2009.
3. The Information Centre, *Mental Capacity Act 2005: Deprivation of Liberty Safeguards Assessments (England). First report on annual data, 2009/10*, 2010.
4. The Mental Health Alliance, *Deprivation of Liberty Safeguards: an initial review of implementation*, July 2010.
5. G v E and others (2010) EWHC 621 (Fam).
<http://www.bailii.org/ew/cases/EWHC/Fam/2010/621.html>
6. HM Government, *Deprivation of Liberty Safeguards Code of Practice*, 2008.
7. The Care Quality Commission, *Monitoring the use of the Mental Health Act in 2009/10*, October 2010. p43
8. The Mental Health Alliance, *Deprivation of Liberty Safeguards: an initial review of implementation*, July 2010, p6.
9. Department of Health, *Briefings on Legal Cases*, February 2010.
10. Department of Health, *Briefing on Mental Capacity Act Deprivation of Liberty Safeguards*, April 2010.

© Care Quality Commission 2011

Published March 2011

This publication may be reproduced in whole or in part in any format or medium for non-commercial purposes, provided that it is reproduced accurately and not used in a derogatory manner or in a misleading context. The source should be acknowledged, by showing the publication title and © Care Quality Commission 2011.