SUMMARY

Monitoring the Deprivation of Liberty Safeguards in 2014/15
The Mental Capacity Act and Deprivation of Liberty Safeguards

The Mental Capacity Act 2005 provides the essential framework for people who need to make decisions on behalf of someone else who lacks mental capacity. It sets out who can take decisions, in which situations, and how they should go about this. This should ensure that they act in the person’s best interests and empower people to make their own decisions wherever possible.

Within this framework, the Deprivation of Liberty Safeguards are used to protect the rights of people who are deprived of their liberty so that they can be given necessary care or treatment. The Deprivation of Liberty Safeguards set out the processes that must be followed if a health and social care provider believes that they need to deprive someone of their liberty – including that care homes and hospitals must apply to local authorities for authorisation to do this. The local authority must make sure that a number of specific assessments are carried out before it can grant an authorisation. The Deprivation of Liberty Safeguards also set out the rights of a person or their representative to challenge an authorisation through the Court of Protection, and provide a way of monitoring a deprivation of liberty. Further information is available in the Mental Capacity Act and Deprivation of Liberty Safeguards Codes of Practice.

Other legislation may apply to the admission of people to health and care settings in other situations. For example, the Mental Health Act 1983 is the legal framework for compulsorily treating people with mental health conditions where it is in the interests of their health or safety or the safety of others to do so, alongside the safeguards required to protect their rights whilst receiving such treatment.
WE FOUND

- There has been a tenfold rise in the Deprivation of Liberty Safeguards applications in 2014/15
- Providers’ use of the Deprivation of Liberty Safeguards is variable
- Improvement is needed across the health and social care sector

Summary

There has been a tenfold rise in Deprivation of Liberty Safeguards applications in 2014/15

Since their introduction in 2009, numbers of applications from providers for authorisation to use the Deprivation of Liberty Safeguards were consistently low. However, this changed in March 2014 following the ruling of the Supreme Court which clarified the test for when people are deprived of their liberty. Since then, applications have increased tenfold from 13,715 in the year ending March 2014 to 137,540 by March 2015.

As a result local authorities, who are responsible for processing applications, are under significant pressure. We are pleased that the Association of Directors of Adult Social Services (ADASS) and some local authorities are taking action to deal with this rise in applications, for example through the use of new tools created by ADASS. However, we are also concerned by feedback that some local authorities are advising providers to delay, stagger or minimise the applications they are making, as this increases the likelihood of people being unlawfully deprived of their liberty.

There is still a significant backlog of applications received by local authorities, with 56,835 applications where the outcome was not decided by March 2015, compared with 359 across the previous year. The cause of this increase in the backlog is largely a change in the interpretation of the law rather than a change in the way care is being provided. It does not necessarily mean that people are any more or less at risk of receiving good or poor care. However, the backlog does mean that there is a delay in people who may be deprived of their liberty receiving the independent
Deprivation of Liberty Safeguards applications by area, 2013/14 to 2014/15

Applications 2013/14

Applications per 100k population
- 0 ≤ rate ≤ 100
- 100 < rate ≤ 200
- 200 < rate ≤ 300
- 300 < rate ≤ 400
- 400 < rate ≤ 500
- 500 < rate

London
Applications 2014/15

assessments, advocacy and representation provided by local authorities. These are essential to ensure that people are only deprived of their liberty appropriately and consequently, that they receive care which meets their needs and is consistent as much as possible with their wishes.

**Providers’ use of the Deprivation of Liberty Safeguards is variable**

As we highlighted in our 2015 State of Care report, strong leadership and governance will affect the quality of care that services provide.

These issues are consistent with our findings about the use of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards by hospitals and care homes. Through our inspections in 2014/15, we have found:

- Staff awareness, understanding and training of the Deprivation of Liberty Safeguards varies, despite the Supreme Court judgement clarifying the meaning of ‘deprivation of liberty’.

- Some providers do not have clear and up-to-date policies in place, with processes also not being consistently implemented. This includes making sure that people’s capacity is properly assessed and decisions are made in their best interests.

- We are continuing to find examples where providers may be unlawfully depriving people of their liberty.

- There is continued evidence of low notifications to the Care Quality Commission (CQC) about the outcomes of deprivation of liberty applications. Providers are legally required to inform CQC of Deprivation of Liberty Safeguards applications and their outcome together, when the outcome is known.

Overall, this means that people who use services are not consistently receiving the protections of the Deprivation of Liberty Safeguards, may not be having their human rights protected and may be receiving poor and inappropriately restrictive care that does not treat them with dignity and respect.

**Improvement is needed across the health and social care sector**

Implementing the processes under the Deprivation of Liberty Safeguards and wider MCA is essential to make sure that people are
POSITIVE EXPERIENCE OF DEPRIVATION OF LIBERTY SAFEGUARDS IMPROVING QUALITY OF CARE AND UPHOLDING HUMAN RIGHTS

Mr A had been residing in a particular learning disabilities residential home for more than 30 years. Following the Supreme Court ruling, the provider made a request for a Deprivation of Liberty Safeguards authorisation for Mr A.

When an Independent Mental Capacity Advocate (IMCA) visited Mr A, the staff and management of the home reported that Mr A would refuse to re-enter the home after a trip out, and it sometimes took them an hour to persuade him in again. He would also try to leave when the front door was opened for visitors. They said it was not related to his access to the community, which was once a week.

The IMCA asked the Best Interest Assessor to add a condition to the authorisation that the home should make more efforts to ensure Mr A had access to the community more regularly. Following a change in Mr A’s routine, so that he was getting out about five days a week with a member of staff he particularly trusted, Mr A stopped refusing to re-enter the home and trying to leave when visitors came in. The IMCA continued as his paid relevant person’s representative, closely monitoring his access to the community.

receiving treatment that is in line with the law and is in their best interests. This starts with making sure that staff always follow the processes for making decisions in the best interests of people who lack capacity. For example, for a person receiving care and treatment this means that they should receive an assessment of capacity where appropriate that is time and decision specific, that they are enabled to make the decision for themselves as much as possible, and that care options that are less restrictive
POOR PRACTICE IN THE USE OF DEPRIVATION OF LIBERTY SAFEGUARDS

A woman, whose son had planned respite care throughout the year, was not made aware by the provider of a Deprivation of Liberty Safeguards application being made for him, and did not find out until she was contacted by the local authority as part of their assessment process. As a result, she stated:

“I was shocked and distressed to say the least; I knew of Deprivation of Liberty Safeguards and the reasons for it but nobody had related this to my son and his respite stays. It was the stuff of nightmares, [that is,] key professionals making decisions and not informing or involving me… I found out after the event, that the respite provider should have consulted with me about Deprivation of Liberty Safeguards… [As a result], there was no input from me at this crucial stage, only representation from the respite provider.”

She also reported some difficulties in her experience with the local authority. In particular, she felt that the telephone call she received from a Best Interest Assessor “was a cursory overview of the process, which left [her] more stressed and confused… It was a rushed call and I was not fully informed of what things were.” However, she reported that she had a good experience with a psychiatrist who was involved in the local authority’s process, finding that he ‘approached it from a human perspective’.

Overall, she felt “The whole thing (my son’s assessment) was just a box ticking exercise; it had to be done, so they did.”

than a deprivation of liberty are sought. In accordance with legal requirements the person and any interested relatives or friends must, as far as possible, be part of the process; other people, such as ‘relevant professionals’, should also be involved as appropriate. Providers must also always seek an authorisation where a person may be deprived of their liberty, so that their interests are protected.
We recognise that some providers are doing this well, but we are concerned that we are continuing to find variation between – and sometimes within – providers’ understanding and implementation of the Deprivation of Liberty Safeguards. Care homes and hospitals must have clear and effective systems and policies in place for implementing the Deprivation of Liberty Safeguards, and must make sure that staff understand the Deprivation of Liberty Safeguards and receive relevant training.

We believe that the current pressures on the system are unsustainable, and that the variation we have found in providers’ practice in implementing the Deprivation of Liberty Safeguards is unacceptable. The Deprivation of Liberty Safeguards remain an important protection for individuals.

We welcome the Law Commission’s consideration on the process for authorising deprivations of liberty and await its final proposals for reforming the system. We hope that the final proposals will simplify the system and believe that national action will be needed to respond to the Law Commission’s findings when they are available. The Deprivation of Liberty Safeguards process is the main source of scrutiny and protection for people who may be deprived of their liberty, so simplifying this is essential to make sure that it can be more easily understood and implemented by all. It is therefore important that providers and local authorities follow the current legislation and Codes of Practice to the MCA and the Deprivation of Liberty Safeguards to ensure that people’s rights are protected and that the care they receive is appropriate. Locally, action should continue to be undertaken to work on the backlog. We will continue to monitor the response of providers and the wider system going forward. We will continue to use our inspections and reports to encourage improvements in practice, and challenge providers if they are not meeting legislative requirements which may include taking enforcement action.
CQC actions and recommendations

What providers must do

• Take action to meet the requirements of the MCA, in line with the Codes of Practice for it and the Deprivation of Liberty Safeguards. This includes making sure that their staff understand the MCA including the Deprivation of Liberty Safeguards, have access to training, consistently undertake capacity assessments where it is appropriate for them to do so and apply best interests decision-making processes for people who do not have capacity.

• Make sure that they have in place clear policies and processes relating to the Deprivation of Liberty Safeguards.

• Continue to request authorisations when they think that people may need to be deprived of their liberty, while always seeking less restrictive options to meet individual needs.

• Make sure that they notify CQC about Deprivation of Liberty Safeguards authorisation applications and their outcome (when the outcome is known), so that we can fulfil our monitoring role.
We also recommend

- Local authorities learn from good practice initiatives being put in place by other local authorities, through the Association of Directors of Adult Social Services (ADASS) regional leads programme, and to continue to use available tools such as those created by ADASS.
- Local authorities must not advise providers to delay or inappropriately minimise their applications as this increases the likelihood of people being unlawfully deprived of their liberty.

What we will do

- Clearly define what ‘good’ looks like in relation to the Deprivation of Liberty Safeguards.
- Continue to use our inspections and reports to encourage improvements in practice.
- Continue to challenge providers if they are not meeting legislative requirements, which may include taking enforcement action.
- Continue to ensure that our inspectors are able to recognise good and poor practice, and to improve our own reporting and recording about the MCA, including the Deprivation of Liberty Safeguards.
- Continue our own work and engage with stakeholders to improve the notifications process for providers.
- Continue to engage with the Law Commission as they carry out their review.
The Care Quality Commission is a member of the UK’s National Preventive Mechanism, a group of organisations that independently monitor all places of detention to meet the requirements of international human rights law.