Somerset Partnership NHS
NHS Foundation Trust

Guidance note to accompany the Flowchart "*Identifying a potential deprivation of liberty in a hospital*"

The Supreme Court in March 2014 provided a new definition of 'deprivation of liberty'. The new definition must now be applied- the use of any other definition or the exercise of any personal or professional discretion is highly likely to be unlawful. There are two parts to the new definition, and both must exist together for a situation to be a deprivation of liberty. If a person is *subject to continuous supervision and control* AND they are *not free to leave* , then they are deprived of liberty and, if the person is unable or unwilling to consent to their situation, this should either be authorised (by the MHA, DoLS or via an order from the Court of Protection) or the person's care should be changed immediately to either reduce the level of supervision and control or to allow them to leave should they wish.

It is important to understand that if a person lacks capacity to consent to the supervision/control and inability to leave they may still be deprived of liberty even if they are 'compliant' and making no attempt to leave whatsoever. The Supreme Court said 'A gilded cage is still a cage'

Definitions. Explanations

DoL- Deprivation of liberty. Not to be confused with;

DoLS- Deprivation of Liberty Safeguards- a legal framework within the Mental Capacity Act which authorises the deprivation of liberty of a person in a hospital or care home when the person lacks the capacity to consent to stay and to be subject to continuous supervision and control.

Continuous supervision and control- sadly not defined in law or in case law. The Supreme Court in March 2014 said "I believe that we should err on the side of caution in deciding what constitutes a deprivation of liberty." Therefore in situations where you are unsure whether or not you are providing 'continuous supervision and control', assume that you are and, if the person is also not free to leave, either issue an urgent DoLS authorisation, or request a MHA assessment.

It may help to remember the European Court of Human Rights decision in Bournewood (2004)- the Court observed that the hospital's health care professionals assumed full control of the liberty and treatment of a vulnerable incapacitated individual solely on the basis of their own clinical assessments completed as and when they considered fit. While the Court did not question the good faith of those professionals or that they acted in what they considered to be the applicant's best interests, the very purpose of procedural safeguards was to protect individuals against any misjudgement or professional lapse.

Free to leave- again not defined in law or case law. Importantly whether or not P is trying to leave is irrelevant. Also irrelevant are the risks which the person would pose to themselves if

they left. Ask yourself 'If this person tried to leave the ward, would we stop them?" If the answer is yes, AND the person is subject to continuous supervision and control (see above), then a deprivation of liberty is probably occurring and must be authorised.

Consent- the voluntary and continuing permission of a patient to be given a particular treatment, based on a sufficient knowledge of the purpose, nature, likely effects and risks of that treatment, including the likelihood of its success and any alternatives to it. Permission given under any unfair or undue pressure is not consent. Patients who lack the capacity to consent cannot consent- compliant acceptance of a treatment or intervention is NOT consent.

Lacking capacity to consent-
When it comes to assessing a person's capacity to consent to admission to hospital 'it is not necessary for the person to comprehend every detail of the issue' (Macur J in LBL v RYJ [2010] EWHC 2664), but rather that they are able to comprehend and weigh the salient details relevant to the decision.

It is suggested that, in order to consent to admission, a person must be able to understand and weigh up the following points(where relevant):

(1) that the person is being admitted to hospital to receive care and treatment for a mental disorder;
(2) the nature of the care and treatment – i.e. that it may include varying levels of supervision (including supervision in the community), use of physical restraint and the prescription and administration of medication to treat the mental disorder
(3) that staff at the hospital may be entitled to carry out property and personal searches;
(4) that the person may need to seek permission of the nursing staff to leave the hospital, and, until the staff at the hospital decide otherwise, will only be allowed to leave under supervision;
(5) that if the person left the hospital without permission and without supervision, the staff would take steps to find and return them, including contacting the police.
(6) that if they decide to leave that they might nonetheless be subject to an application made under the statutory holding power under section 5 of the MHA so that they might not in fact be able to leave when they wanted to if those treating them thought they were too mentally unwell to be allowed to leave.

This list is based on the findings in A PCT v LDV (2013).

Best Interests- only of relevance when a patient lacks the capacity to consent to a treatment. Patients with capacity are responsible for their own 'best interests' and are able to make 'unwise decisions' with which professionals may not agree. When it is established that a patient lacks the capacity to make a decision, and we are making a decision for them, we must act in their best interests. The Code of Practice to the Mental Capacity Act (MCA) says:

"Section 4 of the Act explains how to work out the best interests of a person who lacks capacity to make a decision at the time it needs to be made. This section sets out a checklist of common factors that must always be considered by anyone who needs to decide what is

in the best interests of a person who lacks capacity in any particular situation. This checklist is only the starting point: in many cases, extra factors will need to be considered.
When working out what is in the best interests of the person who lacks capacity to make a decision or act for themselves, decision-makers must take into account all relevant factors that it would be reasonable to consider, not just those that they think are important. They must not act or make a decision based on what they would want to do if they were the person who lacked capacity." (paras 5.6 and 5.7)

MCA- The Mental Capacity Act 2005
MHA- The Mental Health Act 1983 as amended by the Mental Health Act 2007.