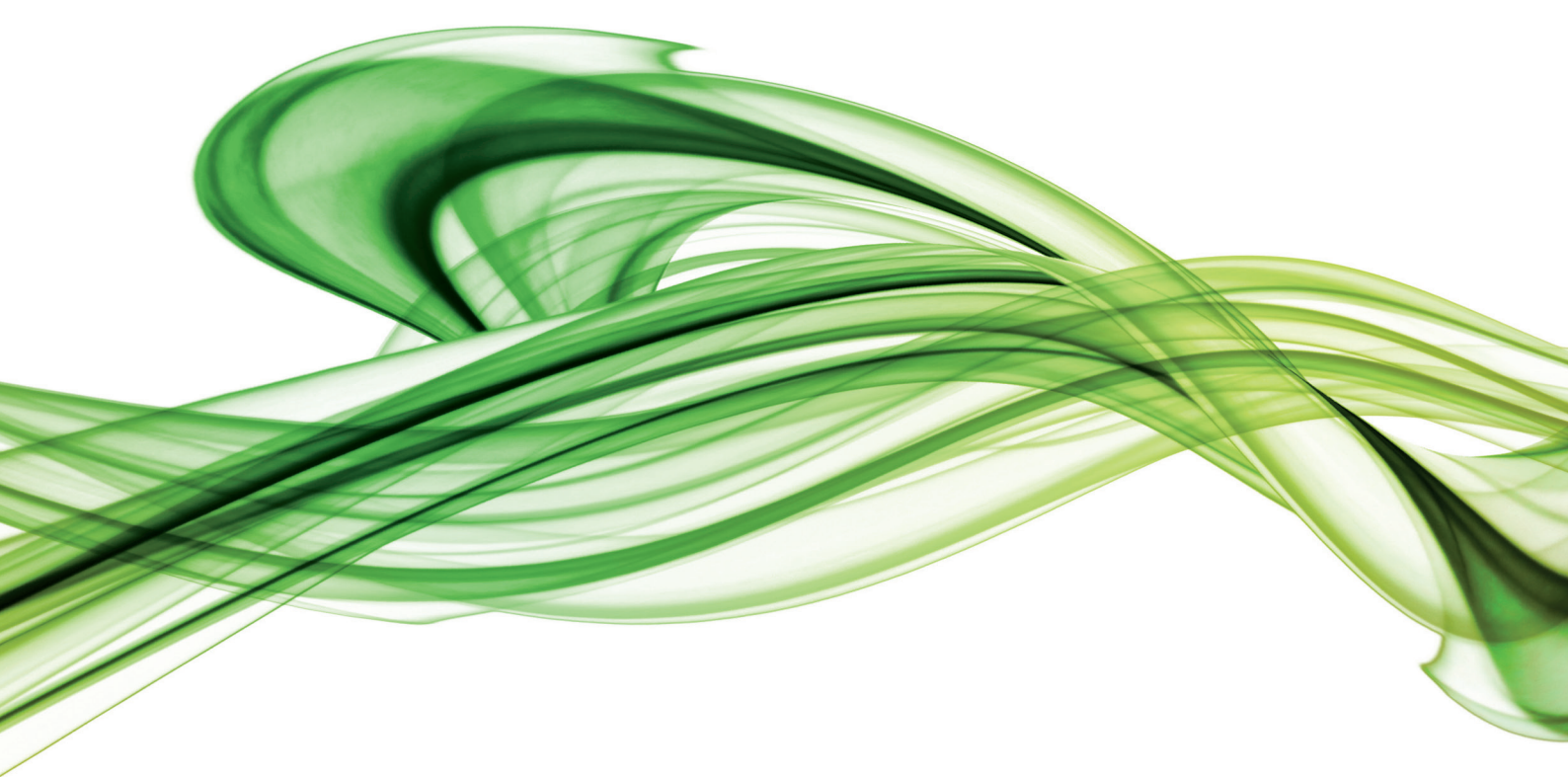




The Law Society

# Identifying a deprivation of liberty: a practical guide

## *Introduction*



This guidance does not constitute legal advice, which must be sought - if necessary - on the facts of any specific individual case. While care has been taken to ensure the guidance is accurate, up to date and useful, no legal liability will be accepted in relation to it.



- 1.1 There are many people in different settings who are deprived of their liberty by virtue of the type of care or treatment that they are receiving, or the level of restrictive practices that they are subject to, but they cannot consent to it because they lack the mental capacity to do so. In most cases, the care and treatment is necessary and is being delivered in their best interests even though it amounts to a deprivation of liberty. The Deprivation of Liberty Safeguards ('DOLS') were brought into force in April 2009 to ensure that professionals applied checks and balances when they had to deprive people lacking capacity of their liberty.
- 1.2 The State is under an obligation to make sure that where deprivation of liberty is delivered by social care or health care professionals, who are in law treated as "State agents," that there is lawful authority for that deprivation. Such authority is required to comply with Article 5(1) of the European Convention on Human Rights ('ECHR'), made part of English law by s.6 Human Rights Act 1998, which places strict limits upon the circumstances under which individuals can be deprived of their liberty.
- 1.3 In March 2014, the Supreme Court handed down judgment in two cases: [\*P v Cheshire West and Chester Council and P & Q v Surrey County Council\*](#).<sup>1</sup> That judgment, commonly known as *Cheshire West*, has led to a considerable increase in the numbers of people in England and Wales who are considered to be deprived of their liberty for the purposes of receiving care and treatment. The Supreme Court decided that when an individual lacking capacity was under continuous or complete supervision and control **and** was not free to leave, they were being deprived of their liberty. This is now commonly called the "**acid test**."<sup>2</sup>
- 1.4 Thus, after reviewing the restrictions on an individual, and if those restrictions amount to a deprivation of liberty, authority must be sought. Depending on the circumstances, that may be by way of a DOLS authorisation, under the Mental Health Act 1983, or by way of a court order.
- 1.5 This guidance was commissioned by the Department of Health to assist those professionals most directly concerned with commissioning, implementation and oversight of arrangements for care and treatment of individuals who may lack the capacity to consent to such arrangement. Its purpose is to provide practical assistance in identifying whether they are deprived of their liberty, and hence to ensure that appropriate steps can be taken to secure their rights under Article 5 ECHR.
- 1.6 To that end, the guidance seeks to draw together the assistance that can be found from the case law decided to date and from the practical experience of the authors, who are all lawyers who (in different contexts) advise upon and act in cases involving questions of deprivation of the liberty. The authors particularly wish to thank the members of the formal practitioner group who provided detailed and helpful assistance at stages in its production, as well as a number of other individuals who provided ad hoc input.<sup>3</sup>
- 1.7 Whilst the guidance was commissioned by the Department of Health, it does not represent a statement of Department of Health policy, but rather the views of the authors.

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1 [\[2014\] UKSC 19](#)

2 Because Lady Hale, at paragraph 48 of the judgment, started her analysis by asking: "[s]o is there an acid test for the deprivation of liberty in these cases?"

3 Full details of the authors, the practitioner group and other acknowledgments can be found in the Appendix.

## A: Audience for the guidance

- 1.8 Whilst we anticipate that some of those who will read the guidance will be legally qualified, the primary audience are frontline social and health professionals who need to be able to weigh up whether an individual they are concerned with may be deprived of their liberty and then to take appropriate action. To that end, its primary focus is upon the practical application of the legal principles in the most common care and treatment settings in which questions of deprivation of liberty are likely to arise.
- 1.9 This guidance can be seen as an informal update to Chapter 2 of the Code of Practice accompanying Schedule A1 to the MCA 2005 (often called the ‘DOLS Code’<sup>4</sup>). However, this guidance (unlike the DOLS Code) does not have a statutory basis and professionals do not therefore have to have regard to it in the same way as they do the DOLS Code.<sup>5</sup>

## B: Outline of the guidance

- 1.10 The guidance is divided into chapters as follows:

### Part I: Overview

- Chapter 1: Introduction  
Chapter 2: The law  
Chapter 3: Key questions after *Cheshire West*

### Part II: Specific settings

- Chapter 4: The hospital setting  
Chapter 5: The psychiatric setting  
Chapter 6: The care home setting  
Chapter 7: Supported living  
Chapter 8: Deprivation of liberty at home  
Chapter 9: Under 18s

### Part III: Further information

- Chapter 10: Summaries of key cases  
Chapter 11: Further resources

### Appendix:

Note on authors and the practitioner group and acknowledgments

- 1.11 Throughout the guidance, we provide hyperlinks to freely available transcripts of the case law to which we refer, as well as other relevant materials.

<sup>4</sup> Available at [http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_087309.pdf](http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_087309.pdf)

<sup>5</sup> The status of Chapter 2 of the DOLS Code and the way in which it is to be read in light of subsequent developments is discussed in more detail at paragraphs 2.59 and 2.61.

## C: How to use this guidance

- 1.12 As discussed in more detail in Chapter 2, there is no statutory definition of a deprivation of liberty and so professionals must look to the DOLS Code of Practice, case law since the Code was introduced and this guidance as to what circumstances amount to a deprivation of liberty. Ultimately if professionals and their lawyers cannot agree upon whether a deprivation of liberty is occurring for a particular individual, it would be for a court to determine the matter. At the time of writing this guidance, however, the courts have not yet decided upon how the ‘acid test’ applies to all the contexts with which health or social care professionals may be concerned.<sup>6</sup>
- 1.13 It is the gap between the decisions of the courts to date and the practical circumstances facing professionals on the ground which this guidance seeks to fill, but it is important that those referring to this guidance are clear as to how it is to be used.
- 1.14 In Part II, we detail the most common settings in which a deprivation of liberty may occur. For each, we:
- 1.14.1 Identify a number of factors that may point towards there being a deprivation of liberty. After careful consideration, we have decided that it is not helpful to seek to break these down further to address specific elements of the ‘acid test’ identified in *Cheshire West*, (continuous or complete supervision and control and lack of freedom to leave) but there will be some which go more obviously to one or other limb of the test. We call these factors ‘liberty-restricting measures.’ They are practices that social workers or healthcare staff may or may not normally consider to be restrictive;
  - 1.14.2 Suggest a scenario which we consider is very likely to amount to a deprivation of liberty; a scenario which we consider may amount to a deprivation of liberty; and a scenario (if they exist in any given setting) in which it is likely that the restrictions will not amount to a deprivation of the individual’s liberty. We highlight after each the key factors underlining our thinking. Each scenario is fictitious, as are the names of the individuals used, although some of them are based upon actual cases decided by the courts (and where they are, we make this clear);
  - 1.14.3 Pose a number of questions that professionals can ask to identify which side of the line a specific situation confronting them may fall.
- 1.15 It is important to emphasise that:
- 1.15.1 The test for considering whether to engage the DOLS process, the MHA 1983 or go to the Court of Protection is never whether the professional is **certain** that there is a deprivation of liberty, but rather there is a **risk** of a deprivation of liberty.<sup>7</sup> If there is such a risk, that should trigger further assessment;
  - 1.15.2 Where a scenario is not based upon the facts of a particular case decided by the courts, it cannot be a substitute for a court decision upon similar facts;

<sup>6</sup> The guidance is based upon the law as it stands in February 2015; at chapter 11 we provide useful resources which can be used to keep up to date.

<sup>7</sup> See *AM v South London and Maudsley NHS Trust* [2013] UKUT 0365 (AAC): “... the DOLS regime ... applies when it appears that judged objectively there is a risk that cannot sensibly be ignored that the relevant circumstances amount to a deprivation of liberty” (paragraph 59, emphasis added).

- 1.15.3 It may well be that some of the scenarios that we outline provoke debate and discussion amongst front-line professionals - especially those we identify as being a potential deprivation of liberty. If nothing else, this means that if professionals come across similar facts they should stop and think very carefully about whether they are confident about whether they represent a deprivation of liberty or not (and, if necessary, seek legal advice);
- 1.15.4 The lists of factors that we identify in each chapter **are not** to be taken as a checklist to be applied mechanically. In some cases, the presence of one factor will be sufficient to indicate that the individual is likely to be deprived of their liberty. In others, several of the factors may be present but the individual may still only be subject to a restriction, rather than a deprivation of liberty, of their liberty. The factors – together with the questions we suggest – are set out to assist in the process of determining whether an individual is or is not deprived of their liberty, a process which ultimately relies upon the application of judgment by the professional(s) concerned.

## D: Limits of the guidance

- 1.16 In addition to the limitations set out immediately above, we make clear that:
- 1.16.1 The guidance does not provide detailed answers to the question of what should happen where a deprivation of liberty has been identified. A short answer is set out at paragraphs 2.41 to 2.43, but it is outside the scope of this guidance to provide detailed answers, which will depend upon the precise circumstances in which the deprivation of liberty has arisen. Professionals should note that the Law Commission is currently examining the question of how deprivation of liberty in the context of the delivery of care and treatment should best be regulated and authorised. It is anticipated that a consultation paper will be forthcoming in the summer of 2015 and a final report (and draft legislation) in the summer of 2017;<sup>8</sup>
- 1.16.2 This guidance is primarily addressed to the position in England and Wales: the considerations that arise in respect of Northern Ireland and Scotland, in particular in relation to the authorisation of deprivation of liberty,<sup>9</sup> are sufficiently different that space precludes consideration of these jurisdictions. It may nonetheless be useful for frontline professionals confronted with the same questions as their counterparts in England and Wales;
- 1.16.3 For the reasons discussed at the start of chapter 9, this guidance is deliberately limited in respect of those under 18 to 16 and 17 years olds lacking capacity to take the material decisions;
- 1.16.4 This guidance does not constitute legal advice, which must be sought – if necessary – on the facts of any specific individual case.

<sup>8</sup> For more detail, see <http://lawcommission.justice.gov.uk/areas/capacity-and-detention.htm>

<sup>9</sup> For an overview in the context of proposals to amend the relevant legislation in Scotland, see <http://www.scotlawcom.gov.uk/law-reform-projects/adults-with-incapacity/>

## E: The bigger picture

1.17 There are three crucial ways in which this guidance needs to be seen as part of the bigger picture.

*Why are we concerned about deprivation of liberty?*

1.18 In order to understand why deprivation of liberty is only part of a bigger picture, it is important to stop and ask **why** we are concerned about whether a person is deprived of their liberty?

1.19 As important as the procedural steps required to authorise a deprivation of liberty are (including the right to challenge that deprivation of liberty<sup>10</sup>), it is almost more important in this context to remember that professionals are working with individuals who cannot take decisions about some of the most fundamental issues in their lives. Because such decisions are taken by others, these individuals are extremely vulnerable.<sup>11</sup> Therefore professionals must focus on whether the **whole care and/or treatment package** is in the best interests of the person who cannot consent to it because they lack the capacity to do so. In other words, the starting point must be a consideration of whether the arrangements made for them – their placement and the care and/or treatment plan around them – are in their best interests having regard to less restrictive alternatives. This represents – or should represent – no change to the normal approach adopted by health and social care professionals to the delivery of care and treatment of those without capacity.

1.20 In some circumstances that placement and those arrangements may amount to a deprivation of the person's liberty. If so, then professionals must seek authority for that deprivation. That they must do so – we emphasise – is not a reflection of anything 'wrong' being done by the professionals in terms of the delivery of care or treatment, but rather the proper operation of the law.

## Deprivation of liberty is not the only issue

1.21 Many individuals whose situations may amount to a deprivation of liberty will also have decisions made for them by professionals about important aspects of their lives. Those decisions may or may not relate to steps amounting to a deprivation of liberty but are very likely to involve decisions that relate to the person's private and family life.

1.22 Respect for private and family life, one's home and correspondence, is a right guaranteed by Article 8 ECHR. Where the decisions do interfere with Article 8, (contact with family being the most obvious example), they can only be justified if they are necessary and proportionate and addressed to the individual's specific situation rather than – for instance – to assist the easier management of the placement.

1.23 Professionals must also appreciate that decisions as to whether to prevent or control a person's contact with others have a greater impact on that person when they are also deprived of their liberty. The European Court of Human Rights ('ECtHR') has emphasised how much more personal autonomy means for those who are the subject of 'authorised' deprivations of liberty.<sup>12</sup>

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<sup>10</sup> See further paragraph 2.10.

<sup>11</sup> See paragraph 57 of the judgment in *Cheshire West*.

<sup>12</sup> See *Munjaz v United Kingdom* [2012] ECHR 1704 at paragraph 80, in the context of detention under the Mental Health Act 1983.



- 1.24 Further, professionals should always remember that authority to deprive someone of their liberty does not, itself, provide authority to provide care and treatment to them. If a person does not have capacity to consent to take decisions in this regard, then it will always be necessary to consider the basis upon which those decisions are being taken by others and their authority for doing so which, will, in general terms, be:
- 1.24.1 On the basis of the provisions of ss.5-6 MCA 2005<sup>13</sup>, in terms of the delivery of ‘routine’ care and treatment;
  - 1.24.2 On the basis of a court order, where the care and treatment goes beyond the ‘routine;’
  - 1.24.3 In some circumstances, on the basis of the provisions of Part IV of the Mental Health Act 1983 (but only ever in relation to the provision of medical treatment related to the individual’s mental disorder).
- 1.25 In other words, no one should assume that just because the deprivation of liberty is authorised that this is the end of the story for that individual.

## The need for a plan

- 1.26 As noted above, this guidance does not seek to answer the question of what individuals, organisations and public bodies are to do when there is a deprivation of liberty. However, we conclude this introductory chapter by emphasising the importance of organisations and public bodies having in place proper policies and procedures both to enable staff to identify when a deprivation of liberty may arise<sup>14</sup> and what they are meant to do if it does. Only if such policies are in place can front-line professionals get on with their primary task of making arrangements and caring for individuals, confident that they know what to do if those arrangements and that care amount to a deprivation of liberty.

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13 Which serve – in essence – to protect those delivering care and treatment from legal liability if they reasonably consider that the person in question lacks the capacity in relation to the relevant matter and that they are acting in the person’s best interests

14 Which may well include a specific indication as to what the particular organisation considers amounts to a ‘non-negligible’ period of time: see further paragraphs 3.29-3.32.