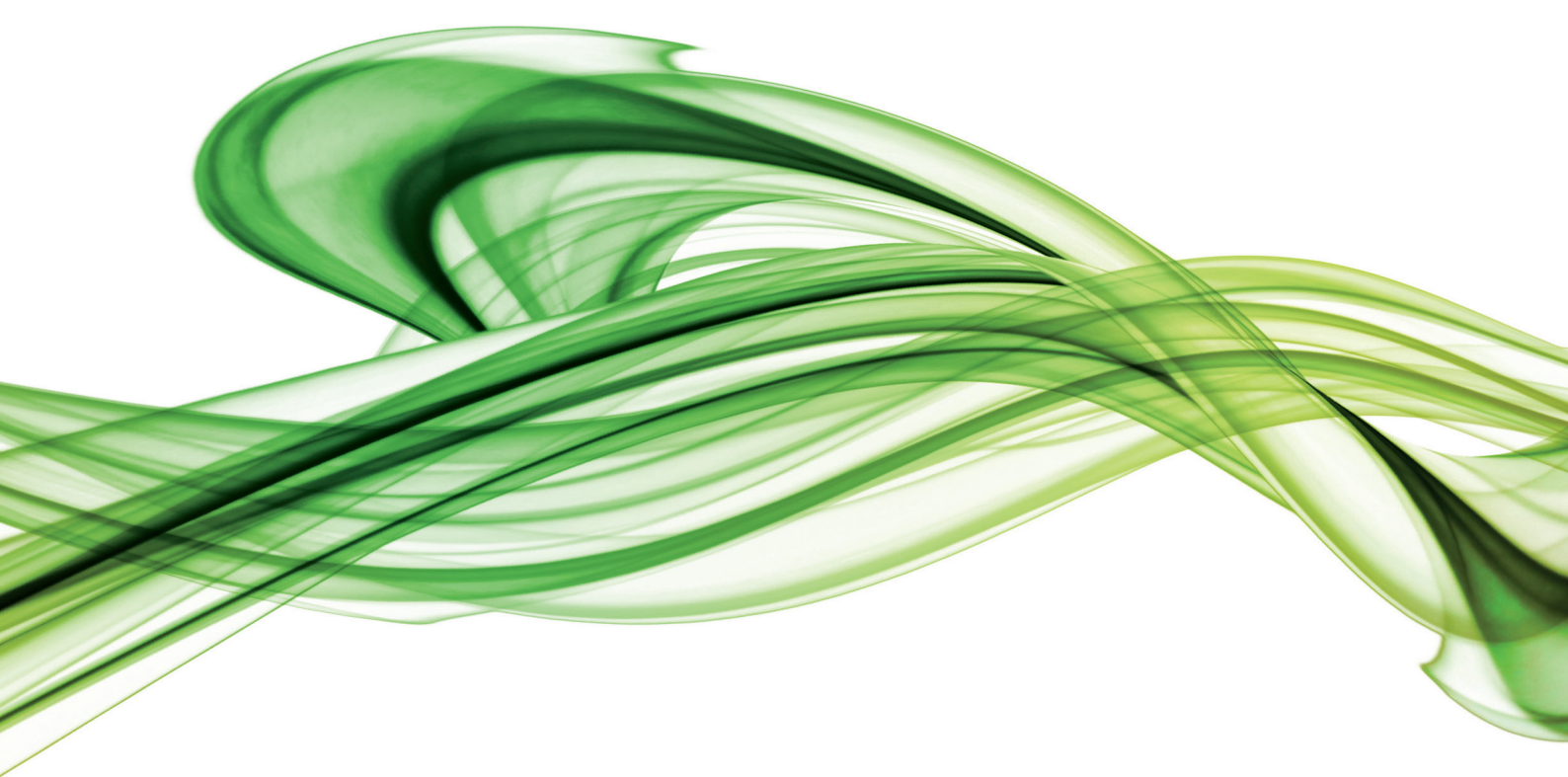




The Law Society

Identifying a deprivation of liberty: a practical guide

The psychiatric setting



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.

A: Introduction

- 5.1 This chapter considers how to identify deprivation of liberty in psychiatric hospitals. These vary greatly depending on the level of security and the client group.
- 5.2 Please also see Chapters 6 and 7 which consider two different types of community settings where residents may be subject to powers under the MHA 1983, such as conditional discharges, Community Treatment Orders (CTOs) and Guardianship.

B: Hospitals

- 5.3 A “hospital” is defined in s.275 National Health Service Act 2006 as:
 - (a) *any institution for the reception and treatment of persons suffering from illness,*
 - (b) *any maternity home, and*
 - (c) *any institution for the reception and treatment 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, and “hospital accommodation” must be construed accordingly.
- 5.4 The same definition appears in s.206 National Health Service (Wales) Act 2006. This is also the definition used by the MHA 1983.
- 5.5 Within this broad definition, there is a huge range of hospitals for the care and treatment of people with mental disorders which we will refer to as “psychiatric hospitals.” Secure Mental Health Services comprise the three High Secure Hospitals (Broadmoor, Rampton and Ashworth), medium secure services and low secure services. These are not considered further in this chapter as those cared for in such secure settings will always be liable to detention under the MHA 1983, which provides authority to deprive the patient of his or her liberty for assessment and psychiatric treatment. We consider that the nature of secure settings is such that they will almost inevitably involve a deprivation of liberty.
- 5.6 Identification of deprivation of liberty, or of a risk that cannot be ignored that a particular patient may be deprived of his or her liberty, will be important in settings where the MHA 1983 may or may not be used. These will include:
 - 5.6.1 Acute wards;
 - 5.6.2 Rehabilitation wards or “stepdown” placements;
 - 5.6.3 CAMHS (Children and Adolescent Mental Health Services) wards;
 - 5.6.4 Assessment and Treatment Units (ATUs); and
 - 5.6.5 Dementia specialist units
- 5.7 These settings are provided both by the NHS and the independent sector. In the great majority of cases the patient’s care will have been commissioned by the relevant Clinical Commissioning Group (‘CCG’).¹ In all these settings patients may be treated for their mental

¹ There will be a few occasions where the state is not involved in the patient’s admission, care or treatment but we do not deal with these in the balance of this guidance, largely because any private hospital would still have to seek authorisation for the deprivation of the patient’s liberty under Schedule A1 to the MCA 2005. See further paragraph 2.49.

disorder informally (where the patient is described as an “informal” or “voluntary” patient), provided (1) the care and treatment regime does not amount to a deprivation of liberty; or (2) if it does, they can consent to the restrictions amounting to a deprivation of their liberty.²

- 5.8 If the patient either cannot or does not consent to their admission, assessment and/or treatment for mental disorder in the psychiatric setting, and that admission, assessment and/or treatment will involve a deprivation of their liberty, then authority will be required under one of four routes:
- 5.8.1 the provisions of the MHA 1983;
 - 5.8.2 DOLS, i.e. the provisions of Schedule A1 Mental Capacity Act 2005 (“DOLS”);
 - 5.8.3 (unusually) by way of an order made under the inherent jurisdiction of the High Court;
 - 5.8.4 (unusually) by way of an order made by the Court of Protection.
- 5.9 The decision as to which legal framework to use is outside the scope of this document but will first require an assessment of:
- 5.9.1 whether the arrangements made for the patient’s care and treatment deprives them of their liberty, or whether there is “a possibility that cannot sensibly be ignored”³ that they may do so;
 - 5.9.2 if so, whether the patient can, and does, consent to those arrangements.
- 5.10 In addition to the availability of legal frameworks to authorise deprivation of liberty, practitioners must apply the provisions of the MHA Code of Practice (the ‘MHA Code’), whether or not the compulsory powers of the MHA 1983 are being used. This is because – in addition to giving guidance about the use of the MHA 1983 – the Code provides guidance for “medical practitioners and members of other professions in relation to the medical treatment of patients suffering from mental disorder.”⁴ This also includes treatment in the community.
- 5.11 This guidance looks at the settings set out in paragraph 5.6 and considers how a deprivation of liberty can be identified in each setting. It is worth remembering that all hospitals – whether treating physical or mental disorder – need to run on the basis of a structured timetable. Anyone who has received inpatient treatment in a busy surgical ward will know this can involve surrendering control over many aspects of life, in ways that may not have been anticipated before the admission begins. We stress that the fact that we identify measures that restrict liberty is not a criticism of the care provided: some restrictions are unavoidable. Similarly, where we identify risks that a particular scenario involves a deprivation of a patient’s liberty, this simply means that the patient is entitled to the legal safeguards, in the form of independent checks, required by Article 5. Lady Hale summed this up in the Supreme Court judgment in *Cheshire West*: thus “[n]or should we regard the need for such checks as in any way stigmatising of them or of their carers. Rather, they are a recognition of their equal dignity and status as human beings like the rest of us” (paragraph 57).

2 A patient can only be an ‘informal’ or ‘voluntary’ patient in such circumstances if they have capacity to consent to their admission and treatment and to the restrictions inherent in that admission and treatment, and give that consent freely: see [A PCT v LDV](#) [2013] EWHC 272 (Fam) and paragraph 2.19.

3 [AM v South London and Maudsley NHS Foundation Trust](#) [2013] UKUT 365 AAC

4 S118 (1) (b).



5.12 It should be noted that the Care Quality Commission ('CQC') which inspects mental health services and monitors the use of the MHA has expressed the view that any incapacitated patient who requires psychiatric admission is likely to satisfy the "acid test" for deprivation of liberty.⁵

C: Psychiatric hospitals generally: measures which restrict liberty

5.13 The following are examples of potentially liberty-restricting measures that apply in psychiatric hospitals generally:

- Wards are busy places where there may be a high turnover of patients and significant pressure on staff time. This can result in blanket restrictions. These include: limited access to bedrooms during the day; restrictions on access to parts of the ward such as kitchen areas;
- Setting of observation and monitoring levels;
- Requirements for patients to be escorted in certain parts of the ward or site;
- The physical environment (e.g. wards not on ground level) may limit patients' access to the outdoors;
- The prescription and administration of medication to a patient who lacks capacity to consent to it, in particular medication to sedate and/or to control the behaviour of the patient;
- The extent to which the patient is required to adhere to a timetable;
- Locked doors, or use of "baffle locks", unless patients have the code and are able to come and go as they please⁶;
- The concept of "protected time" is a valuable means of ensuring that patients have quiet periods during the day but also represents control over the activities of patients;
- Limited visiting time;
- Lack of easy access to telephones, internet, equipment for hobbies and interests such as art or music materials, possibly on safety or availability grounds;
- Use of seclusion⁷, especially where such seclusion is regular and/or prolonged;
- Use of physical restraint, especially where such restraint is regular;
- Sanctions, such as time out, for behaviour that causes concern;
- Restriction of access to finances.

5 "Monitoring the Mental Health Act 2013/4" (page 47), available at <http://www.cqc.org.uk/content/mental-health-act-annual-report-201314>.

6 The CQC has noted an increase in the use of locked wards, finding that 86 % of the wards visited in 2013/14 were locked: see page 47 of its report: [Monitoring the Mental Health Act in 2013/4](#)

7 Seclusion is defined in the 2015 MHA [Code of Practice](#) (available at <https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983>) at 26.103 as "the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others."

D: An Acute Ward

5.14 Many patients admitted to psychiatric hospitals will be treated in acute wards. These wards can be very busy depending on the pressure on admissions at the time. Acute wards are not usually intended to be long-stay settings and as such the make-up of the client group will change and may at times be volatile, with patients presenting with a range of different disorders, at an early stage in their recovery.

Acute Ward: a deprivation of liberty

5.15 The measures in the following scenarios are likely to amount to a deprivation of liberty:

Miss Sara Wong, aged 59, has had mental health issues for many years and has a diagnosis of schizophrenia. She lives on her own now that she has retired and neglects her personal care and her diabetes is not well managed. She is non-compliant with diet guidance and does not like taking her anti-psychotic medication. It is winter and her central heating boiler is no longer working. She is reluctant to spend money on a new boiler.

Due to her increased paranoia, and threats to neighbours who she accuses of spying on her, a decision is made to admit her to hospital under s.2 MHA 1983 for assessment. She is admitted to the acute ward of the local psychiatric hospital. She becomes cooperative with taking medication and after some weeks, as she agrees to stay on the ward, she is not made the subject of an application under s.3 MHA 1983 at the end of the 28 day period of her initial section, but remains on as an informal patient.

Miss Wong thinks that she is on the ward for treatment of her diabetes and her bad foot. She has agreed to stay on until her foot is better and states that when the doctors tell her she is ready for discharge, she will return home. A formal capacity assessment as to whether she can consent to informal admission has been conducted and Miss Wong is considered to lack such capacity.

A discharge planning meeting takes place attended by the hospital's social worker. The psychiatrist is concerned about Miss Wong's ability to cope on her own, and suggests that she may also have dementia but is awaiting scan results. The psychiatrist recommends that Miss Wong be placed in residential care. No relatives in England have been identified.. The social worker agrees with the psychiatrist that Miss Wong lacks capacity to make a residence decision as she cannot weigh up the risks of returning home and it is feared that once home, she will revert to her habits of not letting the district nurses visit to check her foot and diabetes and also that she will not allow the CPN to check that she is taking her medication. She has also refused a key safe, as she fears that it will include a spy camera and that neighbours will use it to enter her home.

Miss Wong has not asked to go out. However, the hospital is on a very busy road and staff consider it would not be safe for her to go out without staff. She could go out with family but no family have been found. If Miss Wong wanders into the male ward, she is redirected to her own ward. There is a key pad on the door and no one can leave, even visitors, without staff entering the code.

Key factors pointing to a deprivation of liberty:

- *The level of supervision and control on the ward*
- *Miss Wong is not free to leave temporarily without staff present or to go home.*

Acute Ward: potential deprivation of liberty

5.16 We suggest the measures in the following scenario may give rise to a deprivation of liberty:

Mr Nicholas James has treatment resistant schizophrenia with co-morbid physical problems. He is to be started on clozapine (a drug that needs considerable physical monitoring). Although this can be done in the community, the team consider it would be preferable and more efficient to do this in hospital, because of concern that Mr James will not attend appointments for monitoring on time. Mr James lacks capacity to consent to treatment as he believes the treatment offered is for an alien infection not a mental disorder. He is happy to come into hospital as an inpatient and receive tablets as this is, he thinks, appropriate treatment for an infection. He thinks it irrelevant that this is a psychiatric hospital as he states that as there are doctors and nurses there who can help him. When on the ward, the staff would be concerned were he to seek to leave while the treatment gets under way and would have to consider invoking s.5 MHA 1983 to prevent him leaving pending assessment for admission under the Act.

Key factors pointing to a potential deprivation of liberty:

- *The level of supervision and control on the ward*
- *the level of monitoring required in relation to clozapine and the need for staff to consider invoking s.5 MHA 1983*
- *that Mr James may be on the acute ward for a number of days;*
- *whether Mr James would in fact be deprived of his liberty would depend in large part upon exactly what plan the staff would have if he sought to leave and the planned length of his admission.*

Acute Ward: not a deprivation of liberty

5.17 We suggest that the following scenario is unlikely to amount to a deprivation of liberty:

Ms Razia Ahmed has sought help for feelings of depression and hopelessness. She has capacity to consent to admission to hospital for assessment and treatment and has and continues to consent. The consent includes an understanding and agreement that there will inevitably be some restrictions on her movements and that she will be asked to follow the advice of staff about when to leave the ward, and for how long. Ms Ahmed recognises that meals and visits are at set times. She is aware that she may be offered medication, as well as other treatment such as talking therapies, but is not obliged to accept it.

Key factors pointing away from a deprivation of liberty:

- *Ms Ahmed has capacity to consent to the admission and the attendant restrictions upon her liberty.*

E: A rehabilitation or “step down” ward

5.18 This setting will share some of the features of the acute ward, and many of the measures outlined at paragraph 5.13 are likely to be present. The nature of such placements is that for therapeutic reasons a very structured timetable may be present, which patients are expected to adhere to. Patients are likely to move to these placements at a relatively advanced stage in their recovery and the client base will be more stable as patients are likely to remain for longer.

Rehabilitation ward: a deprivation of liberty

5.19 We suggest the measures in the following scenario are likely to amount to a deprivation of liberty:

Mr Alfred Smith has a long history of mental illness. He has a diagnosis of schizophrenia. He has been detained many times under section 3 MHA and has relapsed between admissions. He has held a tenancy in supported living but has neglected himself and his flat is a health hazard. He uses drugs and this is said to compound his problems. He is very pleasant when well but when ill can be aggressive and unpredictable. He has a number of negative symptoms and although it is suspected that his cognitive functioning is impaired. A referral has been made for neuropsychological testing. He always holds residual delusional beliefs and lacks capacity to make decisions about where to live and his care arrangements. He was moved to a locked rehabilitation unit as he has lost many of the skills relating to Activities of Daily Living. He is complying with the timetable but has not yet got escorted leave.

Alfred was detained under s.3 MHA 1983 and applied to the Tribunal. Somewhat to the surprise of the clinical team the Tribunal discharged him on the basis that he would remain informally and he has in fact continued on the ward with the current care plan, which involves a significant degree of oversight over his activities because he is not safe to carry out many Activities of Daily Living unaccompanied. Staff are aware they may need to review this in view of the lifting of the section.

Key factors pointing to a deprivation of liberty:

- *Alfred is not free to leave the locked ward (and when he gets leave, it will be under escort).*
- *Alfred is under supervision and control on the ward, particularly whilst carrying out activities of daily life.*
- *Rehabilitation or “step down” ward: potential deprivation of liberty*



5.20 We suggest that the measures in the following scenario may give rise to a deprivation of liberty:

Ms Mary Smith is in her 60s with chronic schizophrenia and has been in a cycle of admissions and relapses for many years. She has lived a chaotic life in the community and is street-homeless. She has been in hospital for the past twelve months and has recently moved from an acute ward to a rehabilitation ward. Her psychotic symptoms are controlled by medication but she has significant negative symptoms. Her consultant thinks she may additionally have some cognitive defects. She has lost many of the skills related to the Activities of Daily Living. The aim of the placement is to help her rebuild these and the plan – which she supports – is for her to move into supported accommodation for those with severe and enduring mental health problems. She is compliant with medication which is administered partly orally and partly via depot. However, she needs to be prompted as she would forget otherwise. The ward has a structured timetable: Ms Smith is expected to get up at 8am and is prompted to attend to her personal hygiene which she tends otherwise to neglect. She is encouraged to choose healthy options for breakfast which she helps to prepare and tidy up. She is then encouraged to tidy her bedroom, do her laundry and attend a community meeting with other patients. Each weekday she has a timetable which could involve going to a day centre, attending a cooking class, doing some shopping, or attending a keep fit class. At the end of the day she is encouraged to go to bed no later than midnight. There are limited facilities on the ward for cooking but she is expected to prepare simple meals and snacks. She is discouraged from reliance on takeaways but there is a weekly pizza or curry evening for everyone. There are also organised activities such as trips to the cinema with other patients. The majority of the time Ms Smith accepts and appears to welcome the structured timetable on the ward as part her rehabilitation. Ms Smith would not be allowed to leave the ward unaccompanied without the permission of the clinical team, but can go out with permission when the staff know where she is going.

Key factors pointing to a potential deprivation of liberty:

- *Ms Smith is not free to leave and there is a degree of supervision and control over her on the ward and when she leaves the ward.*
- *A key factor will be the extent to which it can be said that this represents ‘support’ as opposed to supervision and control. In light of MIG’s case (discussed further at paragraph 2.26), we suggest that caution would need to be exercised before such a conclusion is reached.*

Rehabilitation ward: not a deprivation of liberty

5.21 The following scenario is unlikely to amount to a deprivation of liberty:

Ms Naomi Archer is 66 and has schizophrenia. She has a history of alcohol abuse. She has been detained under s.3 MHA 1983 for the last year. Prior to her admission to hospital she had been living in a hostel but was evicted as a result of her behaviour when drinking. Her mental health had deteriorated and she was thought-disordered, aggressive and delusional when she was admitted.



Ms Archer spent 6 months on an acute ward and her section was renewed. She has made good progress and her psychotic symptoms have receded significantly. She has managed to remain abstinent from alcohol. She continues to hold a number of delusional beliefs including that she has been abducted and an impostor put in her place. She does not believe that the hospital is a real hospital. When she was admitted to hospital she found these beliefs frightening and distressing but now can tolerate them. She has been assessed as lacking capacity to decide where to live. She has been on the rehabilitation ward for the last six months. The plan is for Naomi to move to highly supported accommodation when she leaves hospital and she is on the waiting list for a particular place she has visited and liked very much. The clinical team have made plans for Naomi to be discharged from the hospital as soon as a place is available. If she were to insist on leaving her care co-ordinator would make an urgent referral to the local authority's homelessness team to secure bed and breakfast for Naomi until her care home place comes up and would arrange support in the community for her until then.

Naomi takes part in the ward programme and at one stage had four hours' unescorted leave a day which she used to visit the library, or spend time with her cousin who lives nearby. She appealed to the Tribunal and at the hearing said she was willing to stay in "this place, whatever it is" until she was allocated a room at the new placement. The Tribunal discharged her on the basis of her agreement to remain. Naomi's responsible clinician has made it clear to her that she can come and go from the ward as she pleases and is no longer restricted to four hours unescorted leave. She appears to enjoy taking part in ward activities and rarely spends more than four hours off the ward.

Key factors pointing away from a deprivation of liberty:

- *Naomi is free to leave*
- *Careful examination of whether the arrangements on the ward amount to continuous supervision and control will be necessary to reach a decision.*

F: A CAMHS ward

5.22 The Child and Adolescent Mental Health Services ('CAMHS') setting will share some of the features of the acute ward, and many of the measures outlined at paragraph 5.13 are likely to be present. However, the environment should be suitable for their age which allows for their personal, social and educational development and with access to age appropriate leisure activities and facilities for visits from family and carers.⁸

5.23 Where a 16 or 17 year old with capacity refuses admission, consent from those with parental responsibility cannot be relied upon: s.131(4) MHA 1983. Nor can such consent be relied upon where someone under 18 lacks capacity or competence to consent or refuse care arrangements which amount to a deprivation of liberty: *RK v BCC, YB and AK*.⁹ For further details regarding the 'nuanced' acid test for those under 18, see chapter 9.

⁸ See generally chapter 19 of the *Mental Health Act 1983 Code of Practice* (2015), available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/395494/mh-code.pdf, due to come into force in April 2015 subject to Parliamentary approval.

⁹ [2011] EWCA Civ 1305.

A CAMHS ward: a deprivation of liberty

5.24 The measures in the following scenario are likely to amount to a deprivation of liberty:

Anna is 16 years old and suffers with severe anorexia. She is admitted to a locked CAMHS ward with a very low body mass index and is refusing food. As she lacks capacity to make dietary decisions or her care and treatment arrangements more generally, given the risk of damage to her organs it is decided with her parents that she will require nasogastric feeding or PEG feeding through her stomach wall which, it is anticipated, she is likely to resist. Physical or chemical sedation will therefore be required to minimise risk of harm and she will not be able to leave her hospital bed for a number of weeks during the re-feeding process.

Key factors pointing to a deprivation of liberty:

- *the use of physical/chemical sedation during the course of her stay on the ward*
- *her lack of freedom to leave*
- *It is important to also note that if Anna is deprived of her liberty, this falls outside the scope of parental responsibility: see further paragraph 9.5. The use of the MHA 1983 will be required to authorise her detention and psychiatric treatment.*

A CAMHS ward: potential deprivation of liberty

5.25 We suggest that the measures in the following scenario may give rise to a deprivation of liberty:

Jon is 16 years old and his concerned mother organised his admission to the locked ward. He suffers from a nervous condition and a chronically neurotic state of mind. The conditions on the ward are as similar as possible to a real home and, whilst there he is regularly observed by staff. He needs permission from staff to use his phone, receives no medication but is engaged in talking and environmental therapies. He is allowed to leave the ward with staff permission, for example to attend the hospital library. He also goes outside to playgrounds and museums with other children, always accompanied by staff. He is able to visit his parents and school friends regularly and, towards the end of his 5?-month hospital stay, starts going to school during the day. On one occasion he absconded and was returned by the police. The restrictions are being relaxed as his treatment progresses.

Key factors pointing to a potential deprivation of liberty:

- *The degree of control over his activities exercised by the staff on the ward and the extent to which they control his ability to leave the ward.*
- *As discussed further in chapter 9, a key factor will be the extent to which it can be said that the conditions imposed upon Jon are akin to those which would be imposed upon any 16 year old young person admitted to hospital.*



Note: this case is based upon the facts of the case in *Nielsen v Denmark*,¹⁰ although the child in question in that case was 12 years old. The ECtHR considered that the circumstances did not amount to a deprivation of liberty because any restrictions upon the liberty of the child arose out of the proper exercise of parental responsibility. We suggest that the logic of this case, which has been criticised, is not necessarily applicable to a young person of 16.

A CAMHS ward: not a deprivation of liberty

5.26 The following scenario is unlikely to amount to a deprivation of liberty:

Debbie is 16 years old and lacking the relevant capacity was admitted in her best interests with obsessive compulsive traits concerning keeping herself and her environment immaculately clean. She has a skin rash from scrubbing herself so hard and her hand have become itchy as a result. Every morning her mother attends the ward to collect her for school and returns her in the afternoon. If the family decide to have dinner at home it is expected that she will come back before 8pm. Often her mother returns her at 4pm. Sometimes Debbie will spend the night with her parents, about which the hospital will be informed. Debbie enjoys school greatly and has excellent grades. She engages with psychological therapy at weekends and staff are available during the weekday evenings to learn to tolerate the idea of germs and also to the risks to her physical and mental health arising from her obsessive compulsive traits. Debbie rarely chooses to go out alone and does not wish to go out without her mother or father.

Key factors pointing away from a deprivation of liberty:

- *Debbie's age and maturity and the involvement of her parents, and the reality that the hospital does not have the degree of control to require her to be on the ward: see further chapter 9 for the application of the 'nuanced' acid test in relation to relatively young children*

G: An Assessment and Treatment Unit (ATU)

5.27 ATUs are specialist in-patient settings for patients with learning disabilities. The level of security of such settings varies. In addition to the features set out at paragraph 5.13 above, some or all of which may be present in ATUs, the CQC has found evidence of a number of restrictive practices in learning disability services.¹¹ These include:

- physical restraint;
- seclusion (often described in misleading terms, not recognized as such and thus not reviewed in accordance with the MHA 1983 Code of Practice);
- blanket rules which were rarely justified by the needs of the individual patient. This can be exacerbated by pressure on staff through low numbers;
- routine and clear boundaries, which can be beneficial and a source of reassurance, but can also entail assuming control over what the individual does with their time.

¹⁰ (1989) 11 EHRR 175.

¹¹ <http://www.cqc.org.uk/content/cqc's-symposium-restrictive-practices>.

- 5.28 It is difficult to identify scenarios in this setting that would not give rise to a real risk of deprivation of liberty (where the individual lacks the material capacity to consent to the restrictions imposed upon them).

ATU: a deprivation of liberty

- 5.29 The measures in the following scenario are likely to amount to a deprivation of liberty:

Mr Jaswant Singh has epilepsy, severe autism and learning disabilities and has a history of failed placements. He is twenty years old. He can display challenging behaviour and this can involve self-harm in the form of banging his head against walls, assaulting others, and causing serious damage to property. A community placement broke down 18 months ago and he was admitted to an ATU informally in the absence of any other available alternative. It has however proved very difficult to arrange an alternative placement partly due to a dispute as to who is responsible for funding his care and partly due to the complexity of his needs. He therefore remains in hospital. He has been classified as a delayed discharge for the past year. He lacks capacity to consent to admission or treatment.

Mr Singh finds it hard to tolerate others. He is able to live in a small self-contained bungalow on the hospital site. This is usually occupied by 2 people but is currently used for Mr Singh alone. Some adaptations have been made, for example handles have been removed from cupboard doors and there are no pictures or ornaments on the walls because Mr Singh would pull them down.

Mr Singh's treatment consists of medication for epilepsy and nursing care. He is encouraged to wear a helmet because of the risk of injury due to head banging. Otherwise, staff attempt to engage him in a programme of activities inside and outside the ward. His day is very structured and tends to follow a very similar pattern as he finds this easy to cope with. Mr Singh is not allowed out of the unit without staff support.

Key factors pointing towards a deprivation of liberty:

- *The degree of supervision and control over Mr Singh's day to day activities at the ATU*
- *The lack of freedom to leave*
- *The indefinite nature of the placement*

H: A dementia specialist unit

- 5.30 Many of the liberty-restricting measures identified above will be present in such settings. In addition the following features may be present:

- The need for restraint and other physical interventions, in the patient's best interests, to deliver personal care;
- Blanket restrictions to avoid risks such as falls

5.31 As such, we consider it highly unlikely that a patient in this setting who lacks capacity to consent to admission will not be considered to be deprived of his or her liberty. A typical example of an incapacitated compliant patient, who is receiving appropriate care and treatment in his best interests but who satisfies the ‘acid test’ is set out below.

Mr James Henry has severe dementia and does not understand why he is in hospital, does not know he is in hospital and is calm and settled following treatment with an antidepressant which has reduced his irritability and resistance to care. He does not try to leave and walks with assistance, though his key risk when walking is that he may fall over. Therefore he is often (though not always) accompanied when he walks.

Personal care is provided by nurses so that he can enjoy cleanliness and comfort. At times he resists them and sometimes this is dealt with by the staff leaving and coming back half an hour later. At other times, care is occasionally imposed by using mild restraint so as to assure his cleanliness.

Mr Henry does not try to leave the ward, accepts care and support and accepts food and drink. If he did try to leave he would be stopped, but in fact he is not trying to leave. If he refused medication and his behaviours and distress returned, he would be treated but he is willingly taking medication although he does not understand the purpose.

Mr James regularly has visitors. His wife holds a health and welfare LPA for him; she regularly attends ward rounds and is fully supportive of his care and treatment.

Key factors pointing to a deprivation of liberty:

- *Mr Henry is not free to leave in that if he attempted to do so, he would not be allowed to do so (in fact he has not made such attempts).*
- *The level of intervention needed to provide safe care for him.*

I. Summary of questions for front-line staff

5.32 These questions may help establish whether an individual is deprived of their liberty in this context:

- Is the door to the ward or unit locked? Does the patient either know the code or have a swipe, and is he or she able to make use of it to come and go as he or she pleases?
- Can the patient leave the ward at any time or are there any conditions the person is required to adhere to?
- How easy is it for the patient to go outside and get access to fresh air?
- What if any steps would be taken by staff if the patient were to announce their intention to leave the ward a) temporarily or b) permanently?
- Is the patient able to access all areas of the ward when they wish to?
- Can the patient prepare any refreshments for themselves?
- Is the patient able to access items for leisure activities when they wish, such as: games consoles, books, means of listening to music, art, craft or writing equipment, the internet?



- What observation levels is the patient on and how are they monitored?
- Is the patient prescribed medication? If so, can they consent to such medication, and what is its purpose? Is it to control their behaviour?
- To what extent is the patient required to adhere to a timetable?
- Does the ward have a period of “protected time” when visitors cannot come onto the ward?
- How easy is it for the patient to use the phone in private?
- What are the visiting hours?
- Is the patient ever nursed alone and if so in what circumstances?
- Is the patient ever secluded? If so, why and for how long on each occasion? Is seclusion regularly used?
- Is restraint ever used and in what circumstances? How often is it used?
- Are there any sanctions used if the patient’s behaviour is cause for concern? If so what are they and why?
- Does the patient manage his or her own finances? If not, who does, why, and under what authority?
- Could any of the liberty- restricting measures be dispensed with and if so how?