2 The **Deprivation of Liberty Safeguards (DoLS)**

Key issues

- **The DoLS scheme is not fit for purpose in its present form – implementation has been extremely uneven, with the result that the protections the scheme is supposed to afford to vulnerable people are effectively unavailable in large parts of the country**
- **Its review and appeals processes do not comply with the requirements of ECHR Article 5(4), largely negating its intended purpose**
- **The scheme is incredibly bureaucratic and wasteful of scarce professional resources, and the burdensome paperwork itself discourages use**
- **Nevertheless, where agencies have managed, with a great deal of effort, to make it work reasonably well, DoLS does perform a valuable protective function and has achieved at least some of the objectives set out for it, demonstrating that there is a need for a measure of this kind**.

2.1 The DoLS scheme

The Deprivation of Liberty Safeguards (DoLS) are an addition to the 2005 Mental Capacity Act, introduced as part of the 2007 Mental Health Act. They were designed to remedy the incompatibility between English law and the European Convention on Human Rights identified in HL v UK, the "Bournewood" case, by creating a procedure whereby people who lack capacity and who need to be protected from harm can, if it is deemed to be necessary in their best interests, be lawfully detained in a hospital or care home.

The DoLS were implemented from 1 April 2009. They apply to people aged 18 and over who are resident in care homes and hospitals and who:

- suffer from a mental disorder– such as dementia or a learning disability
- lack the capacity to give informed consent to the arrangements made for their care and / or treatment and
- are considered to be at risk of harm if they are not deprived of liberty (as per Article 5 of the ECHR).

Care homes and hospitals ("managing authorities") must apply to their local authority or Primary Care Trust respectively (the supervisory body) for an independent assessment of any residents/patients in their care who they believe may require the protection of DoLS. Although the Bournewood case involved a man with a learning disability detained in a hospital, such situations account in practice for only a small proportion of DoLS cases, the majority being of older people suffering from dementia and living in care homes. Seventy-five per cent of DoLS applications are therefore dealt with by local authorities, and they will handle all of them when the PCTs are abolished.

DoLS cannot be used in respect of people living in supported living schemes or other accommodation not registered as a hospital or care home.

2.2 The Alliance's concerns

The Mental Health Alliance has been monitoring use of DoLS through its member organisations, the quarterly statistics (for England) published by the NHS Information Centre, published court judgements, and the reports of the regulators (CQC, CCSIW, HIW).

Our first report on implementation, published in July 2010 (see www.mentalhealthalliance.org.uk/resources/DoLS_report_July2010.pdf) identified a number of worrying trends.

We found:

- much lower than predicted rates of applications and authorisations, and wide disparities in activity rates between comparable supervisory bodies
- poor understanding of the provisions of the main Mental Capacity Act , meaning that care providers did not know when they were exceeding the powers it gave them and would therefore need to apply for a DoLS authorisation
- lack of knowledge and understanding, among care providers and their staff in particular, of the meaning of 'deprivation of liberty'
- resistance to use of DoLS among care providers, in part because of lack of understanding of the process, but also due to widespread anxiety and defensiveness about care standards and practice
- some evidence of resistance among supervisory bodies to appointing family members or carers as representatives of detained persons where it was felt they might challenge use of DoLS
- low provision of Independent Mental Capacity Advocate (IMCA) support, despite the statutory requirement in Section 39D of the Act for supervisory bodies to make this available to detained persons and their family representatives
- a high level of legal and procedural errors caused by the complexity of the scheme coupled with inadequate training
- very low use of the avenues for review and appeal, particularly by family/carer representatives.

At that point, the scheme had been in operation for little more than a year, and these shortcomings could have been no more than teething troubles. However, the scheme has now been in place for more than two years. It is clear that nothing of substance has changed for the better and that the flaws we identified in July 2010 are in fact endemic .

Many of our findings were echoed in the first reports of the regulators in England and Wales, published in March 2011. The CSSIW report for Wales, for instance, noted inconsistent policies on appointment of Section 39D IMCAs and the choice between DoLS and the Court of Protection to resolve disputes with families.

The CQC report for England reported that "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" and expressed concern that the expense and time required to comply with the processes might be a

factor in the lower-than-expected level of use. It also noted that "we came across too many examples of people using services who were being cared for in a way that potentially amounted to an unlawful deprivation of liberty without any consideration of the Safeguards" and "too many examples of managers and staff in hospitals and care homes who were unaware of the Safeguards or who had received no training in them, even towards the end of 2009-10."

The judgement of the Court of Protection in the case of Steven Neary, (June 2011- [2011] EWHC 1377 (COP))- further underscored some of our earlier findings, in particular:

- Inadequate training leading to a lack of understanding of the basic MCA processes and the limits of what can be done under the main MCA
- Lack of understanding on the part of managing authorities of the meaning of deprivation of liberty
- Failure of assessors to comply fully with legal requirements
- The imbalance of power between the statutory authorities and parents or family carers who disagree with them
- The need for automatic appointment of Section 39D IMCAs
- The need for a robust review process compliant with Article 5(4).

Additionally, the judgement highlighted the potential for conflict of interest where the managers in a local authority who were responsible for taking "safeguarding" action involving removal of a person from their family home to a care placement were also responsible for its DoLS function which was intended to prevent the unlawful use of professional authority in such circumstances. This issue had also been identified by the CQC, which said that "services must balance the need to protect a service user with the need to empower them and to protect their rights."

2.2.1 Activity rates

The statistics for England for 2010-11, (the NHS Information Centre July 2011), showed that, although the activity rate increased overall in the second year, with applications up by 26% and authorisations by 51% (thereby reaching the initial government forecast number of authorisations) , the huge variations in activity rates between comparable areas, which had become apparent during the first year of the scheme, appeared to have become entrenched, despite the best efforts of the Department of Health's Implementation Team to reduce them.

For instance , over the two years West Sussex made 206 authorisations, Surrey 21; Ealing 103, Bromley 4; and Leicester 154, Hull none. Second-year figures are not yet available for Wales, but the CSSIW report described similar variations during the first year, noting "different rates of referrals with little correlation with population sizes."

Low rates of authorisation were generally associated with low rates of application – Leicester, for instance, received 241 applications over the two years, Hull only 5. There is strong evidence that the differences in application rates are driven mainly by the different policies of the supervisory bodies, who have been largely responsible for the training and guidance given to staff of managing authorities in their areas. As we pointed out in our first report, many of them expected managing authorities to contact them for advice before making an application, so

creating a “feedback loop” in which the managing authority’s decision on whether or not to make an application would be determined by its perception of the supervisory body’s likely response to it.

This is supported by evidence that where a high proportion of applications is turned down, the application rate falls off in consequence. Surrey, for instance, received 115 applications in year one, but turned down all but 10 of them (8.7% success rate) and got only 32 in the second year of which it agreed 11 (34%), the average success rate nationally being between 45 and 57% over the two-year period.

Despite Department of Health and the regulatory bodies’ concern about these variations, no credible explanation for them has emerged, other than that they reflect widely-differing local interpretations, primarily by the supervisory bodies, of the guidance on the meaning of ‘deprivation of liberty’ in the DoLS Code of Practice. This guidance has not been updated, despite at least 16 published judgements which have gone at least some way to clarifying the meaning since it was drafted .

The government has tended to the view that it is for supervisory bodies and managing authorities to keep themselves up to date on new caselaw and its implications, but undigested judgements are often difficult for non-lawyers to understand or put into context, and very few of the supervisory bodies (over 300 in England alone) or the 20,000 care homes in England and Wales have legal advisers with expertise on this issue. The CQC has asked the Department of Health for “more frequent briefings written in a way which is accessible and more easily applied to practice.”

The extent of this uncertainty about the meaning of “deprivation of liberty” has been starkly demonstrated by recent research conducted by the South London and Maudsley NHS Foundation Trust and the Institute of Psychiatry (Cairns et al, “Judgements about deprivation of liberty made by various professionals: comparison study”, *The Psychiatrist* September 2011.) The researchers gave a series of real-life case examples to a number of lawyers, psychiatrists, IMCAs, and DoLS Best-Interests Assessors (BIAs) (part of whose role within DoLS is to decide whether deprivation of liberty is occurring) and found that the degree of agreement, both between and within the professional groups, as to whether or not the cases involved deprivation of liberty barely rose above the level of statistical significance.

Even the lawyers could not agree among themselves, although they were selected for their in-depth knowledge of the subject. Their consistency of agreement was described as “no better than chance”, leading the authors to question whether more training would improve the situation in the absence of the kind of clear practical guidance being requested by the CQC.

Some supervisory bodies with very low activity rates have claimed that this reflects their success in persuading care providers in their areas to adopt less restrictive care practices. However, this flies in the face of the evidence from the regulators that their inspectors are frequently coming across instances of potential deprivation of liberty and of staff who are ignorant of the legal requirements. It is inconceivable that some supervisory bodies have been 50 times more successful than others in reducing deprivation. The only rational conclusion is that in many parts of the country the Safeguards are simply not reaching the people who they were intended to protect.

2.2.2 Safeguards against misuse of DOLS

DoLS processes must conform to the requirements of Article 5(4). This not only requires that a measure to deprive someone of liberty must include provision which allows them "to take proceedings by which the lawfulness of their detention shall be decided speedily by a court" but, as interpreted by the courts, it must also include provision for regular review as to whether the grounds for detention are still met. The courts have made clear that there is a positive obligation on the bodies responsible for the detention to ensure that these rights can be exercised by the detained person or their representative.

By these standards, the DoLS scheme is deficient on several counts, not just because of failures of understanding or implementation but from flaws in the scheme itself. As the Neary case demonstrated, in the absence of effective safeguards against misuse of the scheme it can become a means by which a powerful public body can give a veneer of legitimacy to its unlawful actions and protect itself from challenge.

The ineffectiveness of the Part 8 review process was highlighted by the judge in the Neary case. It is still little used by detained persons or their representatives; the proportion of authorisations reviewed at their request has fallen between the first and second years, from just over to just under 2%. If the process was seen as effective, and they were being informed of their rights and encouraged to use them, this figure would surely be on a rising trend.

To assist them in obtaining reviews or pursuing appeals, family representatives have a statutory right (Section 39D of the Mental Capacity Act) to support from an Independent Mental Capacity Advocate (IMCA). However in the first year "39D" IMCAs were instructed in respect of just 2.25% of authorisations. While figures for the second 12 months may show an improvement, there remain differences in policy between supervisory bodies, with some appointing an IMCA automatically and others just informing the representatives of their right to ask for one. In the Neary case, the local authority was strongly criticised for its failure for several months to ensure that Mr Neary and his son had the support of a 39D IMCA; only when one was appointed were the legal issues properly addressed.

The Court of Protection is also unsuitable as the avenue for appeal, for reasons explained by the Mental Health Lawyers Association in its August 2011 response to the Legal Aid, Sentencing and Punishment of Offenders Bill:

"The DOL Safeguards are cumbersome and unpopular with nearly all those who have to deal with them. The only appeal avenue is to the Court of Protection at considerable expense. Often, the case has to be heard in London, a long way from where the person subject to the DOLS (and their family and the professionals concerned) is based. DOLS cases are mainly still heard before the senior judiciary, with the effect that counsel is often relied upon. The costs are often many times in excess of the costs of even the most complex tribunal."

These formalities combined with the complexity of DoLS inevitably make appeals a lengthy as well as a costly process, and one with which lawyers paid at current Legal Aid rates may be very reluctant to become involved. Although the government anticipated that 25% of people

detained, or their representatives, would consult a solicitor, it took Mr Neary several months to find one who was willing to assist him, and by the time his son was returned home by order of the court he had been detained unlawfully for nearly a year. Another casein which the local authority was also found to have acted unlawfully, G v E and Others (2010) EWHC 621 (Fam), took 5 months to reach a hearing from the date on which lawyers were first instructed, and it was another 5 months before E's family finally got him home.

In both the Neary and G v E cases the first hearing did take place fairly quickly once the application had actually been lodged. Anecdotally, however, the average delay between application and hearing is between 3 and 6 months, during which time the person will remain detained, possibly unlawfully; this despite the fact that the rate of appeals has been less than half that forecast. This would appear to be a breach of the requirement in Article 5 that the lawfulness of any detention should be 'decided speedily' by a court.

The MHA made 10 recommendations to the government in its July 2010 report, as follows:

1. The government should undertake its own thorough analysis of the reasons for the lower-than-expected level of applications and the large disparities between supervisory bodies
2. The process of educating care professionals in the requirements of the main Mental Capacity Act is far from complete, and needs to be sustained
3. The government should issue revised guidance on the meaning of deprivation of liberty which is more comprehensible to care providers, and especially to staff of care homes
4. The term "deprivation of liberty" gives a negative impression which is creating resistance on the part of service providers. Whilst it is recognised that this term has for legal reasons to be used in the statute and guidance, the government should consider, at the first major review, whether an alternative title could be adopted for the scheme as a whole which would present it in a more positive light. The original intention was to title it "Protective Care" which had much more positive connotations
5. Refresher training for assessors should focus on improving their knowledge of the legal requirements and should emphasise the importance of full compliance with them
6. The government should clarify the ambiguous guidance in the Code of Practice on the selection of family or carer representatives, to make it clear that they should not be regarded as acting contrary to the detained person's best interests solely because they object to the authorisation or are likely to challenge it, and that in selecting them the best-interests assessor or supervisory body must observe the requirements of Section 4 of the Act and caselaw on best-interests decisions
7. In any revision of the Code it should be made clear that the appointment of assessors "suitable to the particular case" is a statutory duty and not just good practice
8. Where a friend or family member is selected as representative, the appointment of a Section 39D IMCA should be automatic unless the representative positively declines it. It is recognised that this will have resource implications, but this is not a valid reason for failure to implement this important provision of the Act
9. Supervisory bodies should be required, by revision of the Code of Practice, to give full written reasons to representatives for declining to implement a request for a Part 8 review
10. The government should consider the implications for the DoLS review process of the High Court's decision in the case of Salford City Council v BJ and issue guidance.

Only one of these recommendations , number 6, has been implemented by Department of Health guidance to supervisory bodies (July 2010) which states that family members should not be passed over for appointment as representatives simply because they opposed the authorisation, and that authorisations should not be used to resolve disputes with families about care arrangements but that these should be placed before the Court of Protection. The latter guidance has been strongly reinforced by the Neary judgement, but it is too early to say to what extent it is being followed in practice.

We believe that the other recommendations are now unlikely to be pursued, given the disbanding of the central DoLS implementation team in England and its regional leads, and the cutbacks in spending which are likely to reduce still further the very small amounts being spent on commissioning Section 39D IMCAs and on the training for all professionals involved in the scheme which is essential if they are to learn to master the excessively complex processes..

2.2.3 Training and education

Although the judge in the Neary case was very critical of the Best Interests Assessors (BIAs) the general level of competence among BIAs appears to have increased greatly over two years, at least in those areas where the level of activity has been high enough to give them sufficient practice experience.

However, medical assessors, who in most places conduct the eligibility assessments that determine whether a person comes under the DoLS or Mental Health Act powers, are still in need of substantial training. The Schedule of the Mental Capacity Act that defines eligibility is almost incomprehensible, even to lawyers. A major recent judgment (GJ v the FT and Others, 2009 EWHC 2972 (Fam)) was also too complex to clarify the situation and there is anecdotal evidence that medical assessors still do not properly understand their legal role or the implications of the court ruling.

2.2.4 Supported living schemes

Another emerging problem is that the DoLS scheme does not apply to a large group of people who have an equal need for protection from unlawful deprivation of liberty. Currently it applies only to residents in hospitals or registered care homes, but deprivation of liberty occurs in supported living schemes, which are now the main type of long-term care provision for people with learning disabilities (eg see G v E). Supported living providers who need to deprive someone of their liberty must apply to the Court of Protection, but this can be an expensive and protracted business and it appears to be happening rarely.

There is no logical reason why those living in supported living schemes, which are often indistinguishable in practice from registered care homes, should have less protection, and why DoLS should not be extended to them. However, the management arrangements of supported living schemes are more varied and complex, and responsibility for care provision is often split between several agencies, making it difficult to determine which of them is in the role equivalent to the “managing authority” in DoLS. Extension of the existing DoLS provisions to this sector would therefore require substantial revision of (and add further complication to) the DoLS Schedules of the Mental Capacity Act..

2.3 Conclusions

The MHA believes that after two years, there is sufficient evidence to conclude that the DoLS scheme in its present form is not fit for purpose. Where the agencies have managed, with a great deal of effort, to make it work reasonably well, it performs a valuable protective function. However, in those areas where application and authorisation levels have been very low, too many vulnerable hospital and care home residents are being left without its protection.

Even where activity levels are high, the benefits achieved are disproportionate to the amount of bureaucracy and expenditure of valuable professional time. The volume of documentation is huge – in England there are 36 standard forms and letters running to 188 pages - and the CQC suggested that the government "should consider whether it may be possible to reduce the amount of paperwork needed ". However, the English forms were designed to incorporate all the requirements of the MCA Schedules (205 paragraphs) and the 40 additional Regulations. Assessors who complete them fully are therefore unlikely to make legal errors, even if their understanding of the Schedules is limited. A reduction in paperwork could therefore be safely achieved only by reducing the complexity of the underlying statute.

Some defects of the scheme might be overcome by more comprehensive guidance and additional training. However, the level of training necessary for staff of supervisory bodies to master its complexities is unlikely to be affordable in the foreseeable future. Many supervisory bodies have disbanded their specialist DoLS teams and management arrangements, and refresher training is as little as a day or two per year. Local authorities are also concerned about further strains on their budgets if they are not fully compensated financially when they take on the supervisory body role of the PCTs on their disbandment.

Additional training would not, in any case, overcome the basic structural flaws of the scheme. In particular, it would not resolve:

- the absence of a statutory definition of "deprivation of liberty "
- the problems around the interface with the Mental Health Act, with which DoLS has to interact but which operates on different and in many respects incompatible principles.
- the lack of compliance with Article 5(4) arising from the inadequacy of the review provisions and the unsuitability of the Court of Protection as the appeal body
- the conflicts of interest which are inherent in supervisory bodies also having an active role in actions which lead to deprivation of liberty
- the lack of protection for anyone deprived of their liberty in care settings not registered as care homes or hospitals

2.4 Recommendations

In view of these basic flaws, the Alliance believes that the scheme should now be either drastically revised, or be replaced by an alternative, more cost-effective way of meeting the requirements of Article 5 of the ECHR in relation to the detention of people who lack mental capacity. The government has commissioned two pieces of research into the operation of DoLS, due to be published in March 2012, but neither piece is tasked with investigating the major concerns about the scheme, in particular the variations in activity rates or the lack of compliance with Article 5(4). That does not therefore constitute a sound argument for putting off a decision on reform until they have reported.

Revision of the two Schedules, A1 and 1A, of the Mental Capacity Act, may not be practicable due to their tortuous construction. Any attempt to amend them would risk making them even less comprehensible and add further bureaucratic burdens. Incorporation of supported living schemes into the Schedules would also not be practicable without major changes to their structure. Nor would this approach resolve the fundamental problem of incompatibility between the MCA and the Mental Health Act.

The more sensible course would therefore be to replace the present scheme with one which preserves its essential purpose but which is much simpler and more straightforward; which can be applied flexibly across the whole range of care provision; which is fully compatible with the Mental Health Act at the points where they interact; which avoids conflicts of interest ; which incorporates effective review processes; and which does not rely on the Court of Protection as the first stage of appeal. The Alliance intends, following consultations with its members, to publish in the near future a further paper setting out a range of options.