

# **SOCIAL WORK WITH ADULTS**



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# SOCIAL WORK WITH ADULTS

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MASTERING Social Work Practice



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# Chapter 6

## Deprivation of Liberty Safeguards (DOLS)

### Meeting professional standards

This chapter will help you to develop the following selected capabilities, to the appropriate level, from the social work Professional Capabilities Framework.

#### Diversity

- Recognise oppression and discrimination by individuals or organisations and implement appropriate strategies to challenge it.
- Identify the impact of the power invested in your role on relationships and your intervention, and be able to adapt your practice accordingly.

#### Rights, justice and economic well-being

- Address oppression and discrimination applying the law to protect and advance people's rights, recognising how legislation can constrain or advance these rights.
- Apply in practice principles of human, civil rights and equalities legislation, and manage competing rights, differing needs and perspectives.
- Empower service users and carers through recognising their rights and enable access where appropriate to independent advocacy.

#### Knowledge

- Demonstrate knowledge and application of appropriate legal and policy frameworks and guidance that inform and mandate social work practice.
- Apply legal reasoning, using professional legal expertise and advice appropriately, recognising where scope for professional judgement exists.
- Understand forms of harm and their impact on people, and the implications for practice, drawing on concepts of strength, resilience, vulnerability, risk and resistance, and apply to practice.

## Intervention and skills

- Demonstrate clear communication of evidence-based professional reasoning, judgements and decisions, to professional and non-professional audiences.

## Introduction

This chapter will be of most relevance to those who are likely to train as best interests assessors (BIAs). Given that a number of local authorities are arranging for all their adult social workers to train as BIAs, to meet a demand which looks set to remain high for the foreseeable future, this potentially covers a large proportion of the qualified professional workforce.

For those who are unlikely to follow the BIA path, there is still a good deal of information in this chapter which is of relevance to practice. Restrictions on liberty, issues of mental capacity, human rights legislation, lessons from case law for practitioners: all of these have a bearing on the wider scope of adult social care practice.

In this chapter we aim to introduce readers to this complex and fast changing area of the law, including a summary of the Bournemouth judgment, the introduction of the Deprivation of Liberty Safeguards (DOLS) framework, and some consideration of how it relates to the safeguarding agenda. In particular we will discuss whether the DOLS are fit for purpose and some of the strengths and weaknesses inherent in the application of the law as it currently stands.

## What are the Deprivation of Liberty Safeguards?

The DOLS became law in April 2009 and apply to all people aged 18, residing in a registered care home or hospital, and who are assessed as lacking in consent to their care and treatment in these settings, where they are subject to care and treatment plans that amount to a deprivation of liberty. DOLS were intended to protect vulnerable adults by offering a right of appeal and an independent assessment of their care and treatment.

The problems in knowing where and when these safeguards apply have been centred around a lack of clear definition of what constitutes a deprivation of liberty and this, alongside other factors, has contributed to the wide variation in the use of the safeguards around the country (CQC, 2014). The landmark Cheshire West judgment in March 2014 (see Significant case law section, pages 96–7) may have resolved this by offering an ‘acid test’ for deprivation, but there still remains significant confusion and panic about this definition. Other problems with the safeguards have been identified as the following: difficulties involved in exercising the right of appeal (obtaining legal aid and advice and speed of access to the Court of Protection); the fact that they only apply to vulnerable individuals in registered care homes and hospitals (not to people in supported living or at home); and a general lack of understanding by care providers of how to use these safeguards.

The House of Lords Committee report (2014) considered the Deprivation of Liberty Safeguards separately from the Mental Capacity Act and concluded:

*The provisions are poorly drafted, overly complex and bear no relationship to the language and ethos of the Mental Capacity Act. The safeguards are not well understood and are poorly implemented. Evidence suggested that thousands, if not tens of thousands, of individuals are being deprived of their liberty without the protection of the law, and therefore without the safeguards which Parliament intended ... The only appropriate recommendation in the face of such criticism is to start again. We therefore recommend a comprehensive review of the Deprivation of Liberty Safeguards with a view to replacing them with provisions that are compatible in style and ethos to the rest of the Mental Capacity Act.*

(House of Lords, 2014, p93)

This is a clear indictment of the legislation, and initially the government refuted the need to act on this recommendation. There was change of heart within government in September 2014 and there is to be a comprehensive review of the DOLS, by the Law Commission, with a plan to have draft legislation ready for 2017. It may be that a new form of the Deprivation of Liberty Safeguards will be in place by 2018 but, in the meantime, practitioners in health and social care still need to work with the existing law, however faulty or difficult it may be.

## The Bournemouth judgment

The DOLS were inserted into the Mental Capacity Act by the Mental Health Act 2007 and came into force in April 2009. The legislation was specifically designed to fill a gap in the law as identified by the Bournemouth judgment (*HL v UK* [2004]). In Chapter 3 we have provided an historical overview of the legal basis for decision making in health and social care settings, including a discussion of the doctrine of necessity. This doctrine was judged by some to allow the informal treatment of people within a confined setting, but this argument was overturned by the judgment in Bournemouth.

HL was a 43-year-old man who had severe autism and lacked capacity to consent to his care and treatment; he had come to live with his foster carers, Mr and Mrs E, in 1994 after spending 32 years living in hospital. HL had no speech and needed significant support and care. In July 1997 the bus driver who drove HL to a day centre once a week took a different route there, which caused HL to display some challenging behaviours on arrival at the day centre. Due to concerns raised by the day centre staff, HL was informally admitted to Bournemouth Hospital the same day without any consultation with Mr and Mrs E. HL was then kept in hospital (within a locked ward) and his foster carers were not allowed to discharge him; neither were they allowed contact. Mr and Mrs E were not consulted about these decisions and employed a solicitor. There then followed a series of different legal challenges and judgments in the UK courts about the legality of HL's detention, resulting in the House of Lords ruling in 1998 that HL had

not in fact been illegally detained. HL had been allowed to return home to live with his foster carers in December 1997, but Mr and Mrs E were shocked by the condition in which he had returned, and made a video showing him with blackened toenails, scabs on his face and looking undernourished. During his stay in hospital, HL had been put in seclusion and isolation on a number of different occasions.

HL's carers decided to challenge the House of Lords ruling of 1998 and in October 2004 the European Court of Human Rights ruled that HL had been illegally detained. Whereas the House of Lords had considered the issue of unlawful detention under English common law (doctrine of necessity), the ECHR considered HL's case in relation to Article 5 of the Human Rights Act and found that he had been illegally deprived of his liberty as he and his carers had no right of appeal; the absence of procedural safeguards and access to a court was found to be a breach of Article 5(1) and 5(4).

Although the details of this case are well known now to those working in the mental health field, it is worth reiterating them here to provide the background context for the DOLS. Bournemouth set the scene for respecting the rights of vulnerable people who would not necessarily meet the criteria for detention under the Mental Health Act but who nevertheless were in situations that amounted to confinement. The very fact that the DOLS were designed to plug a gap in the law may have some bearing on their perceived failure to date to be properly understood and applied, as this is a law that was devised in a rush and has not yet had time to evolve. Some commentators such as Richard Jones have argued that amending the existing law around guardianship under the Mental Health Act would have been a better way of providing such protection as opposed to introducing a very complicated new piece of law. Jones (2012) remains critical of the safeguards, referring to them as *a mess comprising impenetrable law that provides minimal rights for P and P's carers at considerable cost to the public purse* (Preface to *MCA Manual*, 5th edition).

However, while many experts agree with the bulk of the criticisms, some commentators have provided coherent arguments as to why amendments to guardianship would not have been sufficient. Series (2012), for example, has noted that while guardianship offers some protection of the rights of individuals, it shares a number of weaknesses of the DOLS regime, including the fact that neither regime has an answer to the problem of widespread, de facto unlawful detention. As it stands, there is no clear duty on anybody to seek the authority of a guardian, whereas the DOLS regime at least spells out a requirement for relevant care settings to seek authority from a supervisory body should they become aware of a potential deprivation.

## Definitions of deprivation: the Human Rights and Mental Capacity Acts

As indicated by the ruling in Bournemouth, the DOLS are inextricably bound up with the Human Rights Act 1998, in particular Article 5, the right to liberty,



and Article 8, the right to respect for private and family life. When working with service users such as Rosemary (see pages 4–6), and making decisions about care and treatment and where this should be provided, both articles come into play within the hospital setting and in any proposed 24-hour placement. The Deprivation of Liberty Safeguards are designed to allow practitioners to make decisions for people like Rosemary in their best interests, but to provide a legal umbrella or safeguard so that their rights are considered and respected; and most fundamentally there is a mechanism for appeal. This appeal mechanism is provided by the role of the representative, which we will explore later in the chapter.

This all seems relatively straightforward until we consider that the DOLS were introduced as an addition to the Mental Capacity Act 2005. The link here is again fundamental in that the DOLS only apply to those who have been assessed as lacking capacity to consent to their care and treatment, but discrepancies can occur when considering what might be a restriction on liberty as sanctioned by section 6 of the MCA and what is, in fact, a deprivation of liberty. The Mental Capacity Act clearly allows health and social care professionals to make decisions on behalf of those who lack capacity to consent to care and treatment in their best interests and to use restraint in order to do this, provided that it is necessary to prevent a person coming to harm and that the restraint is a proportionate response to the likelihood of a person suffering serious harm (see *MCA Code of Practice*). Examples of restraints or restrictions that can occur in a person's care include environmental, physical, chemical, levels of observation, one-to-one staffing, restrictions on access to the community, contact and discharge.

### Activity 6.1

Consider Rosemary's case again and make a list of the different restrictions on her liberty while she is in hospital. In particular, consider her inability to move around and the medications that may be used to subdue her agitation.

### Comment

*See the following list for possible restrictions you should have identified.*

- *Environmental: being nursed in isolation*
- *One-to-one staffing for personal care*
- *Low-level physical restraints when Rosemary lashes out*
- *Discharge restrictions*
- *Being unable to move without assistance of others*
- *Possible chemical restrictions – e.g. sedating medications*
- *Lack of access to community.*

## Principle 6 of the MCA

*Before the act is done, or the decision made, regard must be had to whether the purpose for which it is needed can be effectively achieved in a way that is less restrictive of the person's rights and freedom of action.*

This principle is fundamental to all decisions and action that professionals take when working with adults who have been assessed as lacking capacity to consent to care and treatment. As such, this is no different when applying the Deprivation of Liberty Safeguards. For Rosemary, it might mean considering whether time-limited home visits might be in her best interests while she is in hospital or whether there are ways of calming her agitation on the ward without resorting to chemical sedation.

Under the safeguards, the best interests assessor is tasked with identifying first whether a deprivation of liberty is occurring and second whether such a deprivation is in the person's best interests. Until March 2014, when there was a landmark ruling from the Supreme Court (see Significant case law section, pages 96–7), there was a tendency to look at deprivation and define it by identifying restrictions in a person's care and then decide whether the intensity, frequency and duration of such restrictions amounted to a deprivation of liberty. This is the approach recommended by the DOLS *Code of Practice* (Department of Health, 2008a) and by case law until the Cheshire West judgment.

The wide national discrepancies in the use and application of the DOLS, as reported by the House of Lords and others, have a variety of causes. However, there must be some foundation for the discrepancy in this tension between those who see liberty as something that is lost incrementally through increased restrictions on an ongoing basis and those who see liberty as an absolute, which is immediately surrendered and compromised the moment an incapacitous person enters a 24-hour placement. The two approaches do not have to be mutually exclusive, but the writer would argue that the now blanket approach to identifying deprivation may have unintended consequences – namely, that by affording everyone the right of appeal, opportunities to recognise and encourage empowerment, supported decision making and choice within 24-hour care may be lost. By automatically assuming that an individual is deprived of their liberty, there is less room for recognising different models of care and treatment, and supporting those models that sit well within the ethos of the MCA.

## What is liberty?

This is, of course, a question that is far too large and wide-ranging to answer in a social work textbook, but needs some reflection when considering concepts around deprivation of liberty.

Philosophers, writers, anti-slavery campaigners and politicians have grappled with this question over the centuries. As human society has evolved, the variety of ways in which liberty can be perceived has also changed. For example, there is currently

a debate around the ability of governments and/or businesses to spy on civilians by means of mass electronic surveillance, as highlighted by the Wikileaks whistleblower, Julian Assange. Privacy and liberty are now closely linked in a way that historical commentators would not have considered. John Stuart Mill wrote his famous treatise *On Liberty* in 1859 and in this asserts:

*The only purpose for which power can be rightfully exercised over any member of a civilised community, 'against his will is to prevent harm to others. His own good either physical or moral', is not a sufficient warrant.*

(Mill, 1909, p258)

John Stuart Mill argues for the rights of the individual over the powers of government and society as a whole and believes that ultimately society benefits more from allowing individuals to express themselves through opinion or action than if individuals are forced to conform to societal norms and rules. While Mill concedes that the individual must be prevented from harming others, he does not include in his treatise reference to vulnerable people with disabilities and the powers society should have in these circumstances, nor does he provide a definition of harm to others and the extent to which intervention can be justified. It is interesting to note that the rights of the individual as favoured by Mill still have strong political credence today and that these are argued for in the name of individual liberty, despite the fact we may all have far less freedom now than we like to think we have.

## Activity 6.2

Think about how you would define your own liberty. In particular, list those aspects (for example, freedom to decide where you live) that you would not want to lose. Second, try to list factors in your life or environment that impinge on that liberty. How far does your second list represent everyday limitations that you are prepared to accept and how far does it represent loss of liberty? How would these lists change if you were diagnosed with dementia or suffered a serious physical or brain injury?

## Comment

*While Activity 6.2 may leave you feeling that the concept of liberty in different situations is necessarily hypothetical, these are some of the debates that have informed the development of the law around deprivation of liberty. For example, in the Cheshire West case, in the original ruling in 2011, Lord Justice Munby had advocated that a comparative approach should be taken when considering what was or was not deprivation of liberty. Munby suggested that a person who had severe dementia or learning disabilities could not expect the same degree of liberty as the average person on the street.*

This approach was rightly identified as being discriminatory towards those with disabilities and has been completely overturned by the verdict of the Supreme Court in March 2014. Lady Hale commented that she found it *axiomatic that people with disabilities, both mental and physical, have the same human rights as the rest of the human race. It may be that those rights have sometimes to be limited or restricted because of their disabilities, but the starting point should be the same as for everyone else* (P (by his litigation friend the Official Solicitor) v Cheshire West and Chester Council & Anor [2014], paragraph 45).

The comparator approach, as it was known, was indeed discriminatory and caused further difficulties in the understanding and application of the safeguards, but in defence of Munby, there was a common-sense element to his reasoning. An older person in the last stages of dementia will lose the ability to speak, move, feed themselves and/or even swallow. This is not as a result of restrictions imposed on them, but a part of a progressive condition. Does the fact that they have to receive intensive and invasive 24-hour nursing care often in bed render them 'deprived of their liberty'? As the law now stands, the answer is 'yes', but many practitioners struggle with this concept, believing that this extra safeguard is an additional bureaucratic burden without any meaning for the person concerned. There are also unresolved questions over whether people in comas in hospital settings should be assessed under the DOLS:

*It seems particularly odd to think of the unconscious hospital patient receiving life-sustaining treatment as deprived of their liberty, but that may be the consequence of this decision.*

(39 Essex Street Newsletter, April 2014, p13)

## Deprivation of liberty in other contexts

The concept of deprivation of liberty does not only exist in relation to health and social care settings, and legal debates around civil liberties are to be found in other contexts, such as the right to protest and terrorism cases where there are arguments about tagging and curfews in respect of suspects. Until case law relating to DOLS started to develop, courts looked to examples from other areas of law for guidance on the timescale and amount of restriction that might constitute deprivation of liberty. Examples were found in anti-terrorism legislation and the use of control orders, as well as in cases where state authorities such as the police restricted the liberty of people significantly.

In the case of Austin (*Austin v UK* [2012]), it was found that a group of protesters who had been held in a police cordon for eight hours – or 'kettled' – had not had their Article 5 rights breached as the police had acted in a pragmatic way that did not equate to arbitrary detention. There were dissenting voices in this judgment, demonstrating how the concept of liberty can be very much a political as well as a philosophical and legal one.

The DOLS as they stand currently only apply to people who reside in registered hospitals and care homes. This does not mean that deprivation of liberty cannot occur

in other settings such as supported living or domestic settings, and the law requires that the Court of Protection is approached to authorise deprivation in those situations. The duty to do this is placed on either the supported living provider or on the local authority. This duty was not always fully recognised until the Supreme Court ruling in March 2014, which also considered the cases of Mig and Meg (see pages 97–8), who were two sisters with learning disabilities, one residing in a domestic foster care setting, and found that they too were deprived of their liberty. Local authorities are now actively trying to identify cases they need to take to the Court of Protection for authorisation, resulting in further delays for hearings in the courts.

## Significant case law

In the discussions above, we have made a number of references to significant cases, in particular the Cheshire West case. As this case has had a profound impact on the law to date, we will discuss it in detail first and then look at providing references to other cases that have influenced the understanding and application of the DOLS.

### Cheshire West

This case concerned a 39-year-old man, P, with cerebral palsy, Down's syndrome, and learning and physical disabilities. P had been moved to Z House, a spacious bungalow accommodating up to four residents in 2009, from his mother's house after a deterioration in her health and a reduction in her ability to care for P. P attended a day centre five days a week and was supervised by staff when he was there; he was also supervised closely within Z House due to his tendency to display challenging behaviours. P used a wheelchair and needed one-to-one support with his personal care. One of P's challenging behaviours involved shredding his incontinence pads, smearing faeces and ingesting the pads. As a result, a care plan was put in place for P to wear an all-in-one body suit with the fastenings at the back to prevent P from having access to his pads. P's mother supported the placement, and family contact was maintained and encouraged. The fact that the care plans for P were in his best interests was never in dispute; the legal debate hinged on whether the care arrangements were or were not a deprivation of liberty.

In 2011 this case was heard at the Court of Appeal and Lord Justice Munby concluded that P was not deprived of his liberty. (In 2009 a judge had found that it was deprivation.) Munby considered relevant case law at the time but went on to analyse the information in terms of 'context, reason, purpose and motive'. As cited earlier, Munby felt that the reasons and purpose for a placement were relevant for defining deprivation, as was comparing like with like: he did not feel the restrictions placed on P and the loss of liberty relating to this should be equated with the average person without disabilities and the liberty they expected to enjoy. The 'relative normality' of any situation needed to be considered before concluding there was a deprivation of liberty.

This judgment has now been overturned by the Supreme Court, but did at the time lead to further confusion and misunderstanding of where the safeguards applied; in particular, confusion arose where assessors saw that care and treatment arrangements for an individual were in their best interests and so concluded there was no deprivation.

## Supreme Court ruling 2014

The Supreme Court revisited Lord Justice Munby's judgment of 2011 and completely overturned it, concluding that P had been deprived of his liberty at Z House; it rejected the idea that the purpose of a placement was relevant and dismissed the idea that assessors or the courts should consider a comparator when weighing up whether there was deprivation or not. Lady Hale and the other judges agreed on a list of factors they considered were not relevant when deciding whether someone was deprived of their liberty or not:

*The person's compliance or lack of objection is not relevant; the relative normality of the placement (whatever the comparison made) is not relevant; and the reason or purpose behind a particular placement is also not relevant.*

(paragraph 50)

## Acid test

This ruling also issued what is now known as the 'acid test' for ascertaining whether there is deprivation or not in a case – namely, *that the person is not free to leave and is subject to continuous supervision and control*. Both of these criteria have to be met. While there is now general consensus that most people who lack capacity to consent to residing in a 24-hour placement will not be 'free to leave' – i.e. they would be prevented from discharging themselves if they tried to do so – there is still some uncertainty and debate about what amounts to continuous supervision and control. This aspect of the acid test was considered in relation to the cases of Mig and Meg, which were also incorporated into the appeal heard by the Supreme Court.

## Mig and Meg

This case concerned two sisters who became subject to care proceedings in 2007 when they were aged 15 and 16; both had learning disabilities. Mig was placed with a foster mother and attended further education daily with an escort; she never attempted to leave by herself but would have been restrained if she had tried to do so. Meg was moved to a residential placement for people with learning difficulties and complex needs and, in addition to support and supervision, sometimes needed physical restraints and sedating medications. In 2009, Judge J Parker had concluded that neither sister was deprived of her liberty, but in the Supreme Court ruling of March 2014, this was overturned:

*If the acid test is whether someone is under complete supervision and control of those caring for her and is not free to leave the place where she lives, then the truth is that both Mig and Meg are being deprived of their liberty.*

(Lady Hale, paragraph 54)

Lady Hale went on to comment that the extreme vulnerability of people such as P, Mig and Meg made it necessary to err on the side of caution when deciding on whether there is deprivation or not. This link between vulnerability and the use of the DOLS is highly pertinent for all those practising in health and social care.

### *London Borough of Hillingdon v Steven Neary and Ors [2011]*

While to date we have focused in some detail on recent case law that has debated and refined a definition of deprivation, it is worth considering a case where the focus is more about whether deprivation is in a person's best interests or not.

Steven Neary was a young man with autism who usually resided with his father, his main carer. Steven was admitted to respite care one Christmas with his father's agreement but then Hillingdon Social Services decided to keep him longer on the basis of concern as to whether Steven could be cared for at home, mainly due to Steven's weight. Hillingdon refused to allow Steven to return home despite his father requesting this and Steven expressing a consistent wish to do so. No DOLS authorisations were put in place until Steven had been in 24-hour care for four months and, when the safeguards were eventually used, the conclusion was that it was in Steven's best interests to stay there without even considering the possibility of him returning home. When the case did eventually get to court some ten months later, it was decided that Steven had been unlawfully deprived of his liberty and that he should be allowed to return home. There were a number of criticisms by the judge (Mr Justice Peter Jackson) of both the local authority and the best interests assessments. These included the fact that Hillingdon failed to bring the case before the Court of Protection, failed to appoint an IMCA and failed to conduct effective reviews of the DOLS authorisation. In particular the best interests assessors were criticised for not appointing Steven's father as his representative, therefore not enabling him to appeal the deprivation, and for taking the party line of the local authority without giving the case proper independent scrutiny.

Mr Justice Peter Jackson commented: *In this case, far from being a safeguard, the way in which the DOL process was used masked the real deprivation of liberty, which was the refusal to allow Steven to go home.*

There was a view that because the best interests assessors were also employed by Hillingdon, they had not acted independently enough. One of the main impacts of this case on the practice of DOLS has been for the onus to be shifted to the local authority to take disputed cases to the Court of Protection. Before Neary, there

was an understanding that the appeal process rested with the person appointed as representative and that they should then bring the case before the court. Steven's father, however, faced many obstacles before he was able to challenge the DOLS: he struggled to find expert legal advice, initially he was not given the role of representative and, when he was, he was not offered the support of an IMCA. As a result of the difficulties, it is now recognised that the local authority should take the lead in referring disputed cases to the Court of Protection and that any person appointed as representative for someone under a deprivation of liberty should be offered the support of an IMCA.

The other important learning point from this case is that the safeguards should not be used as a way of enforcing a limited view of a person's best interests:

*The DOL safeguard should not be used by a local authority as a means of getting its own way on the question of whether it is in the person's best interests to be in the place at all.*

(Mr Justice Peter Jackson)

## Interface between the Mental Health Act (amended) and Deprivation of Liberty Safeguards

At times when vulnerable adults are in psychiatric hospitals for treatment, it is not always clear which legal framework should be used – i.e. should they be detained under section 2 or section 3 of the Mental Health Act, or should a DOLS authorisation be implemented? There has been case law that attempts to define this and we will cite these for further reading. In essence, however, the current position is that if a person with identified mental health problems is clearly objecting to treatment within a psychiatric hospital, then mental health legislation should be applied as opposed to the DOLS. (See *Northamptonshire Healthcare NHS Foundation Trust & Anor v ML (Rev 1)* [2014])

Case law has also suggested that professionals should consider which is the least restrictive regime for an individual. (*AM v South London and Maudsley NHS Foundation Trust and others* [2013]). Such a distinction is not always clear as some might feel there is less stigma attached to a DOLS authorisation than being 'sectioned' and there are potential differences between which regime offers the most robust appeal process. For example, if Rosemary was subject to section 2 of the Mental Health Act, potentially she could challenge her detention within 14 days of her admission, whereas under the DOLS she could wait a lot longer for her case to be heard at the Court of Protection and this would depend on her representative or the local authority making this challenge for her. Equally if a person is detained under section 3 when in hospital, they then become automatically entitled to section 117 aftercare, which means they will not be expected to pay for future care, for example in a residential setting. No



such entitlement exists with a DOLS authorisation. The interaction between these two pieces of law is complex and even lawyers admit to much head scratching with it, but as a social worker you just need to be aware that there are ongoing debates around this subject. The new Mental Health Act *Code of Practice* also has useful guidance and a flowchart to help professionals decide which piece of law should be used.

## Deprivation of Liberty Safeguards in practice

In the first half of this chapter, we have discussed how and why the DOLS came into force and some of the tensions inherent within them, from both a legal and philosophical perspective. We have also provided a summary and analysis of significant case law, which practitioners should be aware of when considering how and when the safeguards should apply. In this section we will explore how the safeguards work in practice.

If you have felt slightly confused to date by what a deprivation of liberty is, it may help to envisage the safeguard as a legal umbrella that sits over an individual's care and treatment. This umbrella does not necessarily change the care and treatment a person receives or how that person receives it, but it does represent a recognition of the circumstances and offers a right of appeal once it is in place. In order for a deprivation of liberty to be authorised (or sanctioned) in a person's best interests, there is a process (of a very bureaucratic nature) that needs to take place. It is necessary to understand the definitions below to be able to follow the process.

**Managing authority:** The hospital or registered care home where the person is residing.

**Supervisory body:** The local authority which is responsible for funding the person's care or would be responsible for the person, where they are in receipt of health-funded care and treatment or are self-funding.

**Best interests assessor:** A professional (social worker, occupational therapist, psychologist, nurse), who has undertaken the relevant specialist training to undertake this role in relation to the DOLS.

**Mental health assessor:** A doctor approved under section 12 of the Mental Health Act, who has undertaken the necessary training to complete assessments for the DOLS.

**Conditions:** Recommendations that may be attached to any deprivation of liberty authorisation. These recommendations are legally binding, but need to relate either to enforcing the deprivation of liberty or reducing the need for it in future.

**Representative:** A family member or friend of the person or, in the absence of an appropriate person, an IMCA, who is appointed to represent the person and who has a right of appeal over the person's care and treatment.

**Reviews:** These are conducted when a DOLS authorisation is about to expire depending on the timescales set for it or when there are significant changes to a person's care and treatment. Another DOLS authorisation can then be put in place if needed.

## Roles and responsibilities

### The managing authority

By law the hospital or care home where the person is has a duty to identify whether the care and treatment it is providing to an individual might be a deprivation of liberty and, if so, make a referral for that person to be formally assessed. A senior member of staff would then have responsibility to complete two forms known as an 'urgent authorisation' (form 1) and a standard request (form 4). These have to be forwarded immediately to the supervisory body.

The urgent authorisation in effect is the care home or hospital giving itself legal permission to deprive a person of their liberty for seven days until the formal assessments are carried out by the best interests assessor and mental health assessor. The standard request (form 4) also has to be completed at the same time. If there are circumstances where managing authorities identify in advance that they will need to use DOLS, then a standard request can be submitted beforehand and allows 21 days for the assessments to take place.

In reality, the huge upsurge in referrals (33,000 requests between March and October 2014) following the Cheshire West judgment in March 2014 has resulted in the statutory timescales being lost as requests for assessments are being stacked. This has potentially serious consequences for people's rights as there is often a long delay in the assessments taking place and the safeguards being effectively implemented. Note: There is no automatic right of appeal unless a deprivation of liberty is formally authorised in a person's best interests.

The managing authority also has a legal responsibility to ensure that any conditions attached to an authorisation for a person in their care are met. Once a deprivation of liberty authorisation is granted for someone in their care, the managing authority has the responsibility to inform the person concerned, to notify the supervisory body of any changes to that person's care and treatment, and to request a review of the DOLS authorisation when necessary.

### The supervisory body

The supervisory body has the responsibility to receive referrals from the managing authorities and then commission the relevant assessments from best interests assessors and mental health assessors. Most local authorities have arrangements in place to train assessors or to commission such training, but before the changes in March 2014, some

supervisory bodies were contracting solely with independent assessors or through agencies. Given the huge increase in demand for DOLS assessments, there is a rush to train increasing numbers of assessors to meet the demand:

*Unsurprisingly almost every local authority who responded to our FOI request is looking to boost BIA numbers. This is not, however, easy. Training a BIA is costly.*

(McNicol, 2014)

The supervisory body has responsibility for scrutinising the assessments it receives from the best interests and mental health assessors and then to authorise these if they satisfy the requirements (see below). This scrutiny and authorisation are usually undertaken by a senior manager or a panel of managers, who ultimately have the responsibility for ‘signing off’ or authorising the deprivation of liberty. Where best interests assessors are employed direct by the local authority, which is also the supervisory body, there are some concerns that this may lead to a conflict of interest or a tendency for the supervisory body to rubber stamp existing decisions – see details of the Neary case on pages 98–9.

Other responsibilities include collating all the information and issuing the standard authorisations and making sure that all relevant individuals who have been consulted as part of the assessment receive a copy of the paperwork. One of the most important duties for the supervisory body is that of appointing an IMCA (see Chapter 3) for the person who becomes subject to a DOLS authorisation. There are three different types of IMCA that can be appointed in relation to the DOLS depending on the function that the law requires them to perform.

- 39(a) If, when an urgent authorisation is issued, there is no one available to consult in terms of family or friend, then the supervisory body needs to appoint an IMCA so that the best interests assessor can consult with them as part of the initial assessment.
- 39(c) Once the best interests assessor has decided that a deprivation of liberty is occurring in a person’s best interests, then they have a duty to appoint a representative for that person. If there is no suitable family or friend available, then the supervisory body has to appoint an IMCA to this position.
- 39(d) It is now recommended practice for every representative appointed who is a family member or friend to have an IMCA assigned to them so that they have the support of an individual who understands the law and appeal process if they want this.

Supervisory bodies bear the burden of the bureaucracy that bedevils the DOLS process and they require dedicated teams to work through the legal processes and ensure that all the paperwork is issued in a correct and timely manner. Supervisory bodies also ultimately carry legal liability for ensuring that people are not deprived of their liberty unlawfully in their area. This said, if care homes and hospitals do not ask for these assessments by issuing urgent authorisations, then it is hard to see how local

authorities can be held accountable. It is interesting to note that there were no DOLS authorisations in place at the Winterbourne care home, suggesting that the most vulnerable did not receive this safeguard as the care home did not ask for this.

There is a provision in the regulations that allows a member of the public or professional to report unauthorised deprivations of liberty to the relevant supervisory body, but this is as yet not well known or widely utilised (*DOLS Code of Practice*, Department of Health, 2008a, p94).

## Best interests and mental health assessors

These individuals have to undertake the necessary training for roles and are responsible for the six assessments that have to be completed for a DOLS authorisation. These individuals also have a professional duty to ensure that they keep their training up to date and keep abreast of all legal changes that occur. There is some overlap between roles and different areas divide the workload differently depending on their commissioning arrangements. The six assessments are as follows.

1. **Mental health assessment:** This assessment can only be done by the mental health assessor, who has to verify that an individual is suffering from a mental disorder as defined by the amended Mental Health Act 1983. If the doctor assigned decides that the person does not have a mental disorder, then all the assessments will stop and the person will not be eligible for the DOLS.
2. **Eligibility assessment:** This assessment can be undertaken either by the mental health assessor or by the best interests assessor if they are also trained as an AMHP (Approved Mental Health Professional under the amended Mental Health Act). This assessment serves the function of establishing whether a person should be detained under the Mental Health Act as opposed to under a DOLS authorisation. Ostensibly, this can be straightforward as if someone is already detained, under a section 2 or 3, this makes them ineligible for the DOLS. However, there has been legal confusion at times (see pages 99–100) over which law should have primacy. Equally, if a person is subject to a community treatment order or guardianship under the Mental Health Act, this does not automatically make him or her ineligible for DOLS, unless there is a conflict between the requirements of both sets of legislation.
3. **Capacity assessment:** This assessment can be done either by the mental health or best interests assessor and is necessary to establish whether the individual does or does not have capacity to reside in an establishment for the purposes of receiving care and treatment. See Chapter 4 for an analysis of how capacity assessments should be carried out.

One of the challenges involved in a capacity assessment for the purposes of the DOLS is that when assessors are working within statutory timescales (only having three or four days to complete this piece of work), there is little time to

try to support an individual with decision making. Equally, assessors are usually independent and have no knowledge of the person concerned other than what they are given by staff in the 24-hour placement. Note: it is important to remember that capacity assessments are always for specific decisions and the one in relation to the DOLS is quite broad in its remit. Where there are particular safeguarding aspects to a case – for example, concerns about an individual who may have been exploiting or neglecting a vulnerable adult – the DOLS capacity assessment can only really focus on the vulnerable adult's ability to understand their need for care and treatment in a 24-hour setting, not on their relationship with such an individual. This does not preclude separate capacity assessments being carried out around the relationship, and it would be good practice for these to be done.

If the mental health or best interests assessor concludes that a vulnerable adult does have capacity for the purposes of the DOLS, this can often present social workers and other professionals with a sudden challenge, especially if their service user is demanding to leave a 24-hour placement and return home immediately. Once an individual is deemed to have capacity, no decisions can be made for him or her and the legal process stops. In these circumstances it would be good practice for the best interests or mental health assessor to talk to the service user about agreeing to stay where they are for a few more days to allow services at home to be put in place if necessary. Alternatively, if there are serious concerns about the outcome of the capacity assessment, then the supervisory body can recommission the assessment and obtain a second opinion or refer to the Court of Protection for a ruling on capacity (see Chapter 4).

4. **No refusals assessment:** This assessment has to be undertaken by the best interests assessor and serves the purpose of identifying if there are any legal obstacles in terms of advance decisions, LPAs or deputies for health and welfare, which would not allow the DOLS authorisation to go ahead. The existence of someone appointed as LPA or deputy for health and welfare decisions who disagrees about care and treatment arrangements, or a clear advance decision refusing a specific proposed treatment, would trump the legal authority of DOLS and thus an authorisation could not go ahead. It is worth noting that many relatives do make arrangements to take responsibility for a loved one's financial affairs, but fewer have legal authority to make health and welfare decisions; if a relative or friend does have such powers and is in full agreement with the care and treatment arrangements, then the authorisation goes ahead.

On rare occasions there may be problems where the best interests assessor identifies that a person who poses a known safeguarding risk to a vulnerable adult also holds an LPA or deputyship for health and welfare decisions for the adult. The first task of the best interests assessor or you as social worker would be to establish if such a power is valid and has been registered with the Office of the Public Guardian. If it is and there is a clear risk that a vulnerable adult will come to harm if the DOLS

is not authorised, swift action needs to be taken to challenge the individual's role in the Court of Protection. Any deputy or attorney has to act in a person's best interests and if they are not doing so, then this needs a legal challenge before they can be divested of these responsibilities.

5. **Age assessment:** This is completed by the best interests assessor and is purely to verify whether the person is 18 years or above. It is worth noting that the Mental Capacity Act applies to people aged 16 and above, whereas to be eligible for a DOLS authorisation you need to be 18. This discrepancy can catch practitioners unawares, especially as the Mental Health Act applies to children as well as adults.
6. **Best interests assessment:** This is probably the most substantial piece of work out of the six qualifying assessments and, as its name suggests, is completed by the best interests assessor (BIA). The main purpose of this assessment is to establish first if a person is deprived of his or her liberty and secondly, if so, whether the deprivation of liberty is in the person's best interests. As part of this assessment, the BIA has also to be satisfied that the care and treatment arrangements are necessary to prevent the person coming to harm and that the arrangements are a proportionate response to the likelihood of the person suffering significant harm. If the BIA decides that any of these criteria are not met, then the DOLS authorisation does not go ahead. Note: if the BIA finds that a person is deprived but it is not in best interests, then care providers and commissioners are required to act promptly to change the person's care and treatment and/or placement.

In order to complete this assessment, the best interests assessor has to meet with the person and interview them, study all their care plans and discuss these with the managing authority and then consult with all relevant people before completing a substantial piece of written work that needs to be of a high enough standard to stand up in court, should any case be referred to the Court of Protection. It is estimated that doing such a piece of work can take up to ten hours or more depending on the complexity of the case. In the 2011 Neary case (see pages 98–9), Mr Justice Peter Jackson commented that the written best interests assessment is *anything but a routine piece of paperwork. Properly viewed, it should be seen as a cornerstone of the protection that the DOL safeguards offer to people.*

The best interests assessor also has the responsibility of identifying a representative for a person who lacks capacity to choose this person for themselves, and recommending such a person to the supervisory body. The best interests assessor recommends how long an authorisation should last (anywhere between 14 days and a year) and can specify conditions to which the DOL needs to be subject.

We will address some of the challenges the best interests assessor faces in their role at the end of the chapter, particularly in relation to safeguarding issues, but first test out your knowledge with the following questions.

### Activity 6.3

1. Who is responsible for making a request for a DOLS assessment?
  - A. The best interests assessor
  - B. The supervisory body (local authority)
  - C. The managing authority (care home/hospital)
2. Who can exercise the right of appeal over a DOLS authorisation?
  - A. The person themselves
  - B. The appointed representative and/or IMCA
  - C. The supervisory body
3. Who authorises the deprivation of liberty?
  - A. The best interests assessor
  - B. The mental health assessor
  - C. The supervisory body
4. The DOLS as the law stands apply:
  - A. Everywhere
  - B. In registered care homes, hospitals and supported living placements
  - C. Only in registered care home and hospital settings
5. Who can complete the capacity assessment for the DOLS?
  - A. Only the best interests assessor
  - B. Only the mental health assessor
  - C. Both the above.

### Comment

*For answers to Activity 6.3, see the end of this chapter.*

## DOLS and safeguarding

As indicated throughout this chapter, there were fundamental problems until March 2014 in identifying and defining deprivation of liberty. While there are still difficulties in applying the new acid test – for example, intensive care units are struggling with the concept of the potential need for DOLS authorisations at the same time as trying to perform life-saving treatment – there is now less room for disagreement in terms of a definition. What does remain, however, is often a conflict between the desire to protect vulnerable individuals and how far the DOLS can be used for this purpose.

There can be a tendency to conflate fear of a vulnerable person coming to harm with trying to use the DOLS as a blunt tool to force someone to remain in 24-hour care for

protection. This is particularly evident where an individual's capacity to consent to care is borderline and they may well have capacity to choose to return to a situation about which professionals have concerns. In such cases, both the BIA and the mental health assessor need to be vigilant that a thorough capacity assessment is completed and the DOLS assessment results in upholding an individual's Article 5 and 8 rights as opposed to being used purely as a legal holding power for the professionals' ease of mind. As highlighted in Chapter 5, any situations where there is ongoing dispute between family members or where there is a breach of Article 8 will need to be referred to the Court of Protection in addition to any DOLS authorisation that is put in place. Where a vulnerable adult is found to have capacity to decide where to live, but there remain significant safeguarding concerns, then professionals need to approach their legal departments to seek advice about whether the High Court can be approached, possibly to use injunctions against known abusers.

DOLS authorisations are often in place to protect individuals – for example, stopping an older person with memory loss from wandering out at night or on to a busy road, but the purpose of the assessments must be to look at the least restrictive way of achieving this care and treatment with a strong emphasis on respecting the person's human rights. The BIA has to find a balance between the need to prevent an individual coming to harm and respect for their rights, wishes and feelings in the same way that professionals are required to make best interests decisions (see Chapter 5). Frequently, BIAs will use conditions attached to authorisations to try to achieve this balance for a vulnerable person. For example, where an individual with severe memory loss is repeatedly trying to leave a locked environment, the BIA may specify that the care staff take the person out for a walk on a regular basis to try to alleviate this distress and reduce the deprivation they are experiencing.

As highlighted throughout this book, the interface between the MCA/DOLS and safeguarding concerns is not straightforward and professionals need to be capable of working with complexity in situations, where it is not always possible to find a 'right' or 'wrong' answer. The art of balancing the need to protect an individual from harm while upholding their rights is an essential skill for those who train as best interests assessors.

### Activity 6.4

Return to the case study for Rosemary (pages 4-6) and apply what you have learned from your reading to the following questions:

1. What is the deprivation of liberty authorising?
2. If you and others disagree with the conditions attached, are you legally obliged to comply with them?
3. Do you still need to go ahead with your own best interests meeting?
4. What will happen when the DOLS authorisation runs out?



### Comment

*Potential answers are as follows.*

- 1. Hopefully, you have identified that the DOL is a recognition of the fact that Rosemary is not free to leave the ward and that she is under the continuous supervision and control of nursing staff and that this is in her best interests for an eight-week period while longer term plans are made for her care and treatment.*
- 2. The short answer is yes, conditions are legally binding. However, if it is impossible to get the care package you need for trial leave or if Rosemary returned home and care broke down, then she could be returned to the ward environment. You as social worker and the ward staff will need to demonstrate that you have made every effort to comply with the conditions.*
- 3. The answer is yes as your roles and responsibilities under the MCA continue alongside the DOLS authorisation. It may be possible to delay your meeting as to such time as Rosemary has had further assessments either at home or in hospital so as to have more information available with which to reach a decision (see Chapter 5).*
- 4. Either Rosemary will go home or if she needs to remain longer in hospital a review of the authorisation will be carried out and a further DOLS authorisation put in place.*

## Becoming a social worker

If you have not trained as a BIA, you may feel that the intricacies and complexities of the DOLS legislation can be left to those who have. However, as a social worker you will increasingly be coming across situations where DOLS authorisations are in place for your service users and you need to be aware of how the law works and your responsibilities in relation to this.

In particular you need to be aware that your role as social worker continues in relation to best interests decision making for service users alongside any DOLS authorisations and that you retain professional responsibility for decision making, but at the same time paying heed to what an independent BIA has concluded or recommended. If you are newly qualified and unsure of your role in such situations, seeking supervision from an experienced practitioner is fundamental.

In addition to supervision, it may help you to shadow a best interests assessor for an assessment to gain a clear understanding of their role. If you wish to consider training as a BIA you will need to have two years' post-qualifying experience and will then need to be released to take a short Masters-level course at a university which offers the training.

### Chapter Summary

The Deprivation of Liberty Safeguards remain a complex piece of law but if applied thoroughly can be a vital safeguard for the rights of vulnerable individuals. We have highlighted some of

the reasons why historically these safeguards have not always been properly understood or applied, but would argue that the current law (or at least something very similar following the proposed changes in 2018) is likely to remain part of the social and healthcare landscape. Social work has had a long tradition of advocating for people's human rights and as such we need to recognise and embrace the DOLS as a tool to support us in this process.

## Further Reading

The Care Quality Commission ([www.cqc.org.uk](http://www.cqc.org.uk)) is now tasked with monitoring the use of the DOLS regulations via its inspection regimes. For up-to-date overviews, see its annual reports.

Both Houses of Parliament have recently scrutinised the operation and impact of mental health and mental capacity legislation, including the DOLS.

The two reports which emerged from this scrutiny are very revealing and their comments in relation to DOLS are worth scrutinising.

**House of Commons Health Committee** (2013) *Post-legislative Scrutiny of the Mental Health Act 2007*, paras 106–7. London: The Stationery Office.

**House of Lords Select Committee on the Mental Capacity Act 2005** (2014) *Mental Capacity Act 2005: Post-legislative scrutiny*. London: The Stationery Office.

## Answers to questions in Activity 6.3

Q1. Who is responsible for making a request for a DOLS assessment?

C. The managing authority (care home/hospital)

Q2. Who can exercise the right of appeal over a DOLS authorisation?

A. The person themselves

B. The appointed representative and/or IMCA

C. The supervisory body

Q3. Who authorises the deprivation of liberty?

C. The supervisory body

Q4. The DOLS as the law stands apply:

C. Only in registered care home and hospital settings

Q5. Who can complete the capacity assessment for the DOLS?

C. Both the mental health assessor and the best interests assessor.