

The Deprivation of Liberty Safeguards: their impact on care practice

KEY POINTS FROM THE RESEARCH

- Managing authorities (in this study usually care homes, although they may also be a hospital ward) often had to be 'nudged' by others (e.g. professionals involved with the person) to make a DOLS application.
- In this study, a key indicator that someone was being deprived of their liberty was the person attempting to leave where they are, or repeatedly saying that they wanted to leave.
- Best Interest Assessors (BIAs) said the information they needed for their assessment was not always readily available from care home staff.
- Some assessors felt that the limited time allowed to complete their assessments (in particular, the Mental Capacity Assessment) was detrimental to good practice.
- An online factorial survey using vignettes (fictionalised case studies) identified the key factors in BIAs' decisions to authorise a DOLS. Most significant were situations where members of staff were preventing someone who evidently wanted to leave a setting from doing so and the resident's response and family unhappiness with care. Other indicators of staff control, including the use of medication to reduce agitation, restriction of movement and family unhappiness with care were also significant. These factors were consistent with the Code of Practice and case law.

The Deprivation of Liberty Safeguards (DOLS) were introduced in 2009, for use where adults do not have the mental capacity to make informed decisions about their care or treatment in certain settings and circumstances. Under the Safeguards, whenever staff in a care home or hospital believes someone in their care is likely to be deprived of their liberty, they must apply to the local authority for an authorisation to detain them (thus becoming the managing authority). The supervisory body is responsible for carrying out assessments to determine whether deprivation of liberty is occurring, and if so, whether it is in the individual's best interests, or whether care can be provided in a less restrictive manner.

This study examined the implementation of DOLS in England and their impact on care practice, through case studies, interviews and a factorial survey using case vignettes.

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- At the heart of the BIAs' decision-making when authorising a DOLS application was a desire to keep the person safe.
- One impact of DOLS was a detailed scrutiny of care practices. While some care home managers expressed anxiety about this, others felt this level of scrutiny was reassuring in endorsing their practices.

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- A majority of BIAs felt that the DOLS had made a positive impact on the human rights of the people protected by the safeguards, although some were concerned that the appeals process was overly bureaucratic.

BACKGROUND

Protecting people who lack capacity from harm can sometimes be done in a way that deprives them of their liberty. Until recently there were no procedures in place to protect individuals subject to such constraints on their autonomy. Professionals did not have to justify why they were depriving someone of their liberty and there was no means of appeal if this happened.

This changed in 2009 with the introduction of DOLS: formal procedures to protect people who 'for their own safety and in their own best interests' need care and treatment that may deprive them of their liberty, but who lack the capacity to consent to this.

FINDINGS

1. What triggers a DOLS application?

Responsibility for deciding whether to apply for a DOLS authorisation lies with the managing authority (the hospital or care home where the person lives). In this study, it was often the professionals connected to the relevant person who encouraged managing authorities to make a DOLS application.

Where the decision to apply for a DOLS authorisation was initiated by the managing authority, the most common reason given for considering that the care being provided constituted a deprivation of liberty was that the relevant person seemed to be objecting to being in the setting and/or asking to leave it. In several cases the person was actually attempting to leave.

2. Assessments

Following a request for a DOLS authorisation, the supervisory body (i.e. the local authority) must get six different assessments from qualified assessors, including an assessment of mental capacity, mental health and to establish whether the deprivation is in the person's best interests.

GLOSSARY

Relevant person – the person who is the subject of the DOLS application.

Managing Authority – the care home or ward where the person lives.

Supervisory Body (SB) – the local authority, whose role is to agree or not agree the DOLS authorisation.

Best Interests Assessor (BIA) - the assessor carrying out the best interests assessment (usually a social worker).

Mental Health Assessor – the assessor carrying out the mental health assessment (usually a doctor).

Independent Mental Capacity Advocate (IMCA) – someone appointed to support a person lacking capacity in some circumstances and represent their views to those working out their best interests.

Relevant Person's Representative – someone appointed to represent and support the person subject to the DOLS application (usually a relative or close acquaintance).

Paid Representative – an independent person appointed to carry out the same functions as the relevant person's representative, where there is no family member or close acquaintance to do this.

In general, assessors had confidence in their ability to complete assessments, feeling they had received comprehensive training for their role. Some care home staff, however, reported inconsistencies in assessors' decision making. Several assessors said they found the mental capacity assessment most challenging, especially in the limited time available to assess a person's capacity in the case of an urgent (7 day) DOLS authorisation.

Doctors responsible for mental health assessments did not declare any particular problems or challenges in undertaking their role. Several highlighted the importance of undertaking assessments quickly, to minimize distress for the relevant person. Some authorities made regular use of equivalent mental health assessments (e.g. recent assessments already undertaken), particularly where a second DOLS authorisation was sought soon after a first. The use of equivalent assessments caused unease among some BIAs, who felt that the resulting lack of consultation

between assessors was detrimental to the robustness of the assessment process.

As part of the process of completing best interests assessments, BIAs described how they initially read the information on the DOLS application. Some used their local authority databases to trace the person's history. Many mentioned the importance of speaking to the relevant person's social worker, if possible, in advance of any visits. Some found it useful to contact the care home or ward in advance. This was to make staff aware of what information they would need to complete their assessment; to ensure care staff who knew the relevant person were available along with the person's care plans and day to day care records. However, this information was not always clear or readily available to BIAs, which made the assessment process more difficult. Sometimes BIAs were unable to speak to the relative of the relevant person within the timescale of an urgent authorisation; this limited the comprehensiveness of the assessment.

3. Making decisions about DOLS

BIAs were asked if authorising care practices that constituted a deprivation of liberty had caused them any ethical dilemmas or concerns. Many of the BIAs in this sample were concerned about the potential impact of the deprivations on the relevant person's life. They expressed anxiety about endorsing care practices that might restrict family access, or reduce the individual's freedom, but weighed the impact of the DOLS against alternative (or previous) options. BIAs talked about how particular values influenced their decision making, especially trying to be 'as person centred as possible', so that the person in each case was at the centre of the decision making process.

The online survey of BIAs found that a deprivation of liberty was most likely to be identified in situations where members of staff were preventing someone who evidently wanted to leave a setting from doing so. Other apparent indicators of staff control over an individual were also factors in identifying the situation as a possible deprivation of liberty. Thus, the use of medication to reduce agitation and anxiety could be seen as having a restraining function. The presence of regular

distress and agitation was in itself a strong predictor of a deprivation of liberty being identified, presumably being interpreted as an indicator of the person's negative feelings about their situation. Conversely, BIAs were not influenced in their decision making by the resident's condition, gender and age, or the whether they were in a care home or hospital.

BIAs were generally confident about their judgements; social workers, approved mental health professionals and independent practitioners (who were generally the most experienced) were no more or less confident than other BIAs. The majority of respondents cited case law in support of their judgements.

4. The impact of DOLS

External scrutiny of care practices

Some care home managers were reticent about making DOLS applications, fearing that doing so was an admission of a 'failing' on their part in relation to the quality of care provided. However, several felt that the level of scrutiny provided by the DOLS assessment process endorsed their working practices, assuming the care they provided was deemed to be in the best interests of the relevant person.

Changes to relevant person's care

There was tangible evidence to suggest that DOLS processes had led to changes to the relevant person's care (even when the DOLS was not authorised). For example, several people were receiving less restrictive care following the DOLS assessments. This may have been, in part, a consequence of other professionals examining practice, and using their knowledge and experience to make suggestions on how to change care regimes. In some cases, relatives and professionals alike agreed that authorising the DOLS had meant the relevant person was kept in a safe environment, often on a short term basis – while they received treatment.

Changes to care plans

Care plans were not uniformly changed as a consequence of a DOLS authorisation, although in some instances the specific conditions attached were recorded in a separate DOLS care plan. Sometimes, however, care plans were revised to 'more honestly' reflect the care regime that the relevant

person experienced. Some social workers did not know how the DOLS had impacted on the care, or care plans, of service users.

Impact on human rights

As part of the online survey, BIAs commented on the impact the DOLS had made on the human rights of people subject to the safeguards. Most of the 62 respondents said that the DOLS had had either a little (n=26) or a great deal (n=33) of impact. Most were positive about the legislation's potential for improving service users' human rights.

The legislation was said to have produced a more robust system, with greater scrutiny of decisions, more people involved in decisions, better capability of resolving conflicts and enabling practitioners to explain or defend their decisions more clearly. Several made references to these being 'early days' following the introduction of DOLS; they described procedural problems, including the cumbersome and bureaucratic systems involved with appeals. Others referred to the inconsistent and patchy implementation of DOLS, which was seen to have a different impact on client groups or practice settings.

5. Relatives and representatives' views

Contact with the person

Relatives who fulfilled the DOLS representative role had regular contact with their family member – at least weekly and often more regularly. They were kept informed about their relative's situation through a combination of informal discussions with staff when they visited the setting and formal update meetings. Where the person did not have any family members, a paid representative followed a similar approach to keep abreast of the behaviour of the client and to monitor how the care team were implementing the DOLS conditions.

Relatives' contact with BIAs and involvement in decision making

Relatives were generally positive about the contact they had had with the BIA – which was typically face to face, although occasionally over the telephone.

BIAs used meetings to provide information to relatives about the DOLS process, to seek information about the wishes and feelings of

the relevant person and to ask the relatives' views about what they thought would happen to the person if there were no DOLS put in place.

Relatives spoke appreciatively of the opportunity given to say what they felt was the best course of action for their family member. In one case, a relative was able to express concern to the BIA about the quality of care for her son; this concern was ultimately addressed as a condition of the DOLS authorisation.

ABOUT THE STUDY

The study took place in four local authority areas in England. Scoping interviews with DOLS leads in these authorities were followed by data collection from nine 'live' DOLS cases, involving multiple interviews with the managing authority applicant, the relevant person's representatives (and/or Paid Representative), the DOLS assessors (BIAs and MHAs), the supervisory body signatory and (where appropriate) the relevant person's advocate and social worker. The IMCA provider in each of the study sites was also interviewed.

Supplementary data was also gathered from an additional set of care home managers, BIAs, MHAs and SB signatories about individual, anonymised DOLS cases. In total 52 people were interviewed in the case study phase, and 27 in the supplementary stage of the study.

An online factorial survey of BIAs was also conducted to explore the factors that influenced their decision making in DOLS cases.

For articles expanding on these findings see:

Carpenter J, Langan J, Patsios D, Jepson M (2013). Deprivation of Liberty Safeguards: what determines the judgements of Best Interests Assessors? A factorial survey. *Journal of Social Work*, 1–18.

Jepson M, Langan J, Ward L (submitted). The Deprivation of Liberty Safeguards: their impact on care practice.

Jepson M and McCalla L (in preparation). Best Interests Assessors decision making under the Deprivation of Liberty Safeguards.

The study was given ethical approval by the South West 5 Research Ethics Committee. The same committee subsequently approved amendments to the study protocol