



Mental Health Alliance

Briefing Paper 1

Deprivation of Liberty Safeguards: an initial review of implementation

Compiled by Roger Hargreaves, DoLS lead for the Mental Health Alliance

The Mental Health Act 2007 made important changes to the mental health and mental capacity legislation in England and Wales. The Mental Health Alliance, which came together in 1999 to work for humane and effective mental health legislation, is currently assessing the impact of these changes. This is the first of a series of briefings on the implementation of a number of powers set out in the 2007 Act.

Key messages

- The Deprivation of Liberty Safeguards (DoLS), introduced in April 2009, are an important protection. Their purpose is to prevent people who lack mental capacity from being deprived of their liberty unless it is necessary in their best interests to protect them from harm.
- So far there has been less use of this scheme than predicted and there are big variations between different areas.
- Flaws in the scheme and poor understanding of it mean that people's human rights are not being adequately protected.
- Greater use of Independent Mental Capacity Advocates would help implement the safeguards effectively.
- We recommend that the Government undertake a thorough analysis of the implementation procedure, continue the education process, and revise its guidance.

Summary

The Mental Capacity Act Deprivation of Liberty Safeguards (DoLS) were introduced in England and Wales in April 2009. They allow care homes and hospitals to obtain a power to detain residents or patients who lack capacity, if this is necessary in their best interests to protect them from harm. This is an initial review of the progress of implementation based on feedback from Alliance members and other organisations involved in the DoLS process, and which highlights some positive achievements but also a number of emerging concerns.

The aims of the safeguards were universally supported by respondents, and there was a wide consensus that many of those aims have been at least partially achieved. Training and awareness-raising prior to implementation led to reviews of care practices and to the removal of unnecessary restrictions on liberty, and subsequent applications for DoLS authorisations, whether or not they have been granted, have focused attention on individual cases, leading to revision of care plans and in some cases to the commitment of more resources or a move to a more suitable placement.

However, these gains have been very unevenly distributed. The nine-month statistical out-turn for England showed that the overall rate of applications was only one-third of the Government's prediction, and it has also acknowledged that there are huge and persistent variations in activity levels between different supervisory bodies (local authorities and primary care trusts) for which there are no obvious explanations.

The introduction of DoLS is also highlighting a widespread lack of understanding of the main Mental Capacity Act, which means that care providers do not know when they are exceeding the powers it gives them and therefore cannot know when they

need to apply for a DoLS authorisation. This is then compounded by the absence of a proper legal definition of 'deprivation of liberty' or clear guidance about what it actually means in practical terms.

The responses also suggested that there may be widespread lack of adherence to legal requirements on the part of those operating the procedures. Some of this is probably inevitable in the very early stages of a completely new scheme, but if it continues it will be a matter of serious concern given that the courts quite rightly take a strict view about compliance with statute when powers of detention are involved. It is also more worrying given that the safeguards against unlawful or improper action are much less extensive than those provided for people detained under the Mental Health Act.

This would be so even if they were working satisfactorily, but the overwhelming evidence is that they have so far barely begun to function. They depend far too much on family representatives who may be elderly or disabled themselves, and there is far too much scope for supervisory bodies to protect their actions from scrutiny by selecting representatives who agree with them, by removing those who do not, or by failing to provide them with enough information or support and by batting away requests for review. The Court of Protection is also inherently unsuitable as a route for appeals, and the process is heavily weighted against family members and in favour of the bodies which support the detention.

Although the flaws in the safeguards are fundamental, and raise questions at several points about compliance with Articles 5 and 6 of the European Convention on Human Rights, they could nevertheless be substantially ameliorated in practice by the greater involvement of Independent Mental Capacity Advocates (IMCAs). Their current level of participation is far below what was anticipated, and there should therefore be scope to increase it substantially.

The Alliance makes the following recommendations

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. While 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 case law 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.

Background

The Deprivation of Liberty Safeguards (DoLS) were included in the 2007 Mental Health Act as an addition to the 2005 Mental Capacity 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. They were not intended to substitute for use of the 1983 Mental Health Act but to plug the 'Bournewood gap' where people who could not be detained under that Act were *de facto* detained under common law. They came into force in England and Wales on 1 April 2009.

Available information

The DoLS provisions have been in force for just over a year and have generally had a low profile relative to the changes to the 1983 Act, so published information about the progress of implementation is still very limited. The Department of Health collects statistics for England and has now published these for the first nine months (ie, up to 31 December 2009) but has not yet issued any analysis of these figures. This report is based on information provided by the Alliance's own members, which includes feedback from professionals acting as DoLS assessors or co-ordinators, supplemented by a limited survey of other organisations with experience of the implementation process – chiefly the national bodies representing care homes and other care providers, and the employers of Independent Mental Capacity Advocates (IMCAs). This survey generated a total of 25 additional responses.

Many of the views expressed were based on a very limited number of actual cases, and some of the problems reported were teething troubles of the sort which tend to accompany the introduction of any new legislation and which do not necessarily have any long-term significance, but some consistent themes did nevertheless emerge. Broadly in line with predictions, about 76 per cent of applications have come from care homes, and so most of the information which was obtained related to that sector, but it is reasonable to assume for present purposes that the situation in respect of the hospital sector will not be greatly different.

Positive benefits

The aims of the safeguards were universally supported, and there was a wide consensus that many of them had been at least partially achieved. The training and awareness-raising prior to implementation had resulted in reviews of care practices and the removal of unnecessary restrictions on liberty, and subsequent applications for DoLS authorisations, whether or not they had been granted, had focused attention on individual cases, leading to revision of care plans and in some cases to the commitment of more resources or a move to a more suitable placement.

In some instances, authorisations accompanied by conditions had been effective in bringing about improvements in care arrangements which might not otherwise have been achieved. Some respondents also commented that applications resulted in 'unbefriended' residents receiving more visitors and more attention – sometimes more than they wanted! – and in care homes getting input from psychiatrists and community mental health teams who had previously regarded their residents as having low priority.

“We have also had a number of cases where the individual is not being deprived of their liberty, but the assessments and advocacy have raised other aspects of the individual’s life that should be considered. In these situations the supervisory body has arranged reviews of the individual’s care to discuss these issues and arrange for a generic advocate to support the individual further.”

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“As a result of the authorisation the resident, who had not been out of the care home in six months, now receives regular trips out... this has also had a wider impact on other residents who have benefited from a general review of procedures.”

“Although DoLS is a very bureaucratic, and at times really frustrating, process we feel that it is improving life experiences for people whose care involves deprivation of liberty. We are able to put in place short-term authorisation, with conditions, and ensure we review the situation.”

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“I think that the paid representative is really making a difference to what is happening to the individual.”

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Taken from feedback to an MHA survey, 2009

Uneven implementation

However, these gains have been very unevenly distributed. The experience of the respondents was consistent with the nine-month statistical out-turn for England (no figures have been issued for Wales) which showed that the overall rate of applications has been only a third of the Government's prediction; and in addition the Government has acknowledged that there have been huge and persistent variations in rates between different supervisory bodies (local authorities and primary care trusts). It has suggested that low rates in particular areas may in part reflect the greater efforts made by some of these bodies prior to April 2009 to educate care providers, resulting in fewer inappropriate referrals, but the responses to the Alliance tended to suggest that low levels of referral were as likely to be associated with a relative *lack* of activity on the part of supervisory bodies and consequent lack of awareness on the part of 'managing authorities', the care providers.

Opinions differed as to whether the low level of overall activity – with authorisations to deprive of liberty running at about 60 per cent of the predicted rate – was a true reflection of the underlying level of deprivation. Some care provider organisations were very confident, having trained their staff and reviewed their practices, that they were not depriving any residents of liberty, while other respondents, and in particular IMCAs, were equally convinced that the cases so far authorised were just "the tip of the iceberg". They pointed in particular to:

- to a reluctance of care homes in particular to invite external scrutiny
- to the length and complexity of the application forms and subsequent paperwork
- to a high level of resistance amongst providers to the notion that they were 'depriving' their residents of anything.

Two consistent themes also emerged. First of all, the introduction of DoLS was highlighting a very widespread lack of understanding of the main Mental Capacity Act, which meant that care staff did not know when they were exceeding the powers it gave them and therefore could not know when they needed to apply for a DoLS authorisation. One especially common misunderstanding – which appeared to be shared by some best-interests assessors as well as care providers, and which may derive from the tenor of some Government guidance – was that actions which were necessary in the person's best interests would not amount to deprivation of liberty, thereby confusing the person's objective situation with the justification for it.

Secondly, in the absence of a proper legal definition or clear guidance there was great confusion about what "deprivation of liberty" actually meant in practical terms, as distinct from legal theory. The whole scheme depended on the managing authorities being able to recognise that it was happening or about to happen, but care homes and non-psychiatric hospitals in particular lacked the expertise to do this and generally took their cue from their supervisory body, being in many areas expected to seek advice from it before submitting an application. However, there appeared to be no consistency of policy between supervisory bodies, which might in itself explain much of the variation between them in application rates.

- the very wide disparities in rates between neighbouring authorities with similar socio-demographic profiles
- to the fact that most applications tended to come from just a small proportion of providers in an area

Conformity with the law

“The supervisory body says that the low rate of referral may indicate that care providers have an excellent understanding of DoLS and are working to ensure that residents are not deprived of their liberty. From our experience this seems optimistic, as we are still having to speak to care staff about basic elements of the Mental Capacity Act.”

“I suggest that one reason for the low response rates is that managing authorities perceive limited benefits from entering into a heavily legalistic and bureaucratic engagement with supervisory bodies.”

“Care homes do not want outside agencies to be looking at their care practices.”

“We have been doing training for care homes, but the matter is so complex and knowledge base so poor that a single presentation will no more than scratch the surface of what they need to know.”

“The term ‘deprivation of liberty’ gives such a false picture of what in a care home would be a process to safeguard the individual.”

“Some services may be in denial about DoLS as they feel it is bad to deprive someone of their liberty and don’t want to be seen doing it.”

“Relatives and care home staff often get defensive, saying that the person is not deprived of anything, we take care of them well.”

“There is little consistency in judging individual cases.”

Taken from feedback to an MHA survey, 2009

The responses also suggested that there may be widespread lack of adherence to legal requirements on the part of supervisory bodies and their assessors. Some of this is probably inevitable in the very early stages of a completely new scheme, when large numbers of staff have to be trained from scratch very quickly, and an additional factor is that, since applications have been so few, many assessors have as yet done only a handful of assessments, and some none at all, and so are still at or near the bottom of the learning curve. However, if it continues it will be a matter of serious concern given that the courts quite rightly take a strict view about compliance with statute when powers of detention are involved.

The impression is that many supervisory bodies are treating DoLS as an administrative rather than a quasi-judicial process, and that they and their assessors are exercising more discretion than the statute actually gives them. In some instances this may simply be because the inflexibility of the scheme means that to follow it to the letter can sometimes lead to perverse or impractical outcomes, but in other cases it seems more likely to result from ignorance of the law. For instance, there were cases where conditions attached to authorisations were not being implemented by managing authorities but where no action was being taken to enforce them, sometimes because of impasses over funding. However, if an authorisation is given “subject to conditions” it must logically be regarded as void if they are neither complied with nor reviewed and changed.

It was also suggested by several respondents that managers in some supervisory bodies were routinely turning down applications without going through the assessment process. The DoLS Code of Practice appears to invite them to do this, but the statute gives them no discretion *not* to commission assessments once a valid application has been received. It was also said that when they contacted the supervisory body for advice, managing authorities were often being dissuaded from making applications, which may in part explain why the ratio of authorisations to applications in the first nine months was much higher (43 per cent) than the 25 per cent which had been predicted. This may,

however, be a reasonable practice in present circumstances provided that care is taken to give advice only in general terms and not to pre-empt the assessment process or the right of the managing authority to decide whether or not to proceed with an application.

There was also some evidence that supervisory bodies were failing to ensure that assessors had skills and experience “suitable to the particular case”. This is rather surprising given that they have been faced with a much lower number of assessments than most of them planned for, and they should therefore have had less difficulty in allocating assessors with the necessary specialist background, for instance in the care of people with dementia. However, the Code guidance tends to give the impression that the appointment of suitable assessors is just “good practice” when it is in fact a requirement of the statute. Some supervisory bodies have also chosen to rely on small teams of full-time assessors, which will limit the range of specialisms available to them, although there is no reason why they cannot look outside their own team for assessors in the less common specialisms such as acquired brain injury.

Some of these errors may derive from the extreme complexity of the legislation, which has meant that most of those operating it work only from the Code, which is no more than a summary, rather than from the two schedules to the Mental Capacity Act which contain the detail. It may also reflect the very limited

knowledge-base of those running the scheme – many best-interests assessors and their managers, who make most of the crucial decisions, will have had no previous experience of a role of this nature and only one day’s training in the detail of the law.

The medical assessors may have had just one day’s training in total, and there were several reports of difficulties in relation to eligibility assessments, usually carried out by doctors approved under Section 12 of the Mental Health Act, which may stem from the misleading content of their standard training package which would lead them to believe that it is their role to decide between use of DoLS and the Mental Health Act, when the Code makes it clear that this is not the case. There also appeared in some cases to be a failure to realise that “objecting” mental health patients could not be detained in hospital for treatment under DoLS. These problems may have been exacerbated by the judgment in the GJ case ([2009] EWHC 2972 [Fam]) which was issued in November 2009 but not summarised on the Department of Health website until February 2010. Although it clarified an important issue about the extent to which patients in psychiatric hospitals could lawfully be detained under DoLS rather than the Mental Health Act, it was, perhaps inevitably, almost as complex and tortuous as the schedule which it was interpreting, and it is questionable whether the majority of eligibility assessors have actually understood its implications and have adjusted their practice accordingly.

“Conditions set as part of the authorisation are not being adhered to by the managing authority... it has told the supervisory body that it requires additional funding to meet these conditions, but the supervisory body refuses to provide it on the basis that it should be covered by the fees that the home is already being paid. The person that suffers as a result of this is the individual being deprived of their liberty.”

“We felt that the assessors lacked knowledge and experience of brain injury and as such were unqualified to make these decisions.”

“Feedback from managing authorities is that when they raise issues relating to DoLS they are directed to the supervisory body’s lead on DoLS for a decision as to whether to submit an application for authorisation.”

“Most managing authorities are genuinely wanting to ‘talk their situation through’ as this is new and the level of knowledge is understandably low – when I talk to other leads in my area they are emphasising to the caller, as I do, that it is their right to refer in the end, but in discussion most of them quickly tend to conclude that the cases are nowhere near the threshold.”

Taken from feedback to an MHA survey, 2009

Safeguards

The apparent lack of strict adherence to legal process is the more worrying given that the safeguards against unlawful or improper action are much less extensive than those provided under the Mental Health Act. This would be so even if they were working satisfactorily, **but the overwhelming evidence is that they have so far barely begun to function.**

The first essential element is the provision of information to the detained person and their representative. The statutory requirements for the issuing of forms and notices to the parties are exhaustive, basically requiring everything to be copied to everybody at every stage, even where this effectively duplicates information already sent. It was suggested, however, that this approach was actually counter-productive, since there was so much paperwork to process that administrative staff in supervisory bodies were failing to send out the crucial information on time to those who most needed it, or in a form which could be readily understood. This was so even though the number of cases being processed was much lower than anticipated.

It was also pointed out that, since the statute allows no discretion, they might be required to send to the detained person information which the professionals regarded as psychologically harmful to them, and information about them to other parties in breach of their rights under ECHR Article 8. The statute even requires the names and addresses of all “interested persons” consulted to be supplied to other parties without regard to their rights to confidentiality.

Given that most people who are made subject to DoLS will lack the ability to take any action to protect their own interests, the role of their appointed representative is absolutely crucial. In most cases this will be a relative or friend – providers of paid representatives reported very few requests so far. The representative has the power, if necessary, to trigger a formal review of the authorisation or to appeal to the Court of Protection on the detained person’s behalf, and in the light of recent judgments by the court, indicating that if a person lacks capacity to take action on their own behalf, the

substitute decision-maker must give strong weight to any preferences which they are able to express and to the action that they would have been likely to take if they had capacity, it can be argued that a representative has a duty to use these powers if it is clear that the detained person would wish to challenge the restrictions which have been placed upon them.

If the detained person lacks capacity to choose their own representative, the choice is made either by the best-interests assessor or by the supervisory body, and there was evidence that in some cases close relatives who opposed the authorisation were being passed over in favour of paid representatives, or other relatives who supported the action. Where this is done, it effectively allows DoLS to be used to override an objection by the closest relative to a hospital or care home placement without going to court as would previously have been necessary, and to deny them access to the information they would need in order to mount a legal challenge. If this is happening to any significant extent it would be ironic, as the whole scheme came about as a result of a successful challenge by carers who had been deliberately excluded.

The Code could certainly be read as legitimising such action – although it advises that “it should not be assumed that the representative needs to be someone who supports the deprivation of liberty” it also advises that the person selected should be “likely to represent the detained person’s best interests” and the supervisory body has the power to terminate their appointment if it thinks that they aren’t doing so. Clearly, a relative who opposes the authorisation is *not* acting in the person’s best interests as these are perceived by the supervisory body.

However, the appointment of the representative is a “best interests” decision subject to Section 4 of the Mental Capacity Act, and in view of the need to give strong weight to the person’s non-capacitous preferences this points strongly towards the appointment of their closest relative or carer. In addition, when a short-term authorisation is replaced by a fresh authorisation, the consultation requirements in Section 4(7) apply again and the closest relative or carer must be consulted even if they have not been the representative, unless this can be shown to be

“not appropriate” on the basis of the person’s best interests.

If the supervisory body is allowed to choose someone on the basis that they agree with it, or remove them on the basis that they don’t, it can effectively insulate itself against any possibility of challenge. To make matters worse, there is no right of appeal against its appointment or termination of an appointment, and in Wales it can even impose a family representative to whom the person or their court-appointed deputy objects, which, since the representative will normally instruct any legal representative, raises a question as to compliance with the ECHR entitlement to a “fair hearing”.

If a representative does wish to challenge the action taken, they then have to grapple both with the complexity of the procedures and with the very limited avenues for redress; and as it appears that at least two-thirds of those detained under DoLS are over 65, many of their representatives will be elderly too, and may have had little or no experience of dealing with authority and be in a state of distress about what is happening to their loved one.

The Part 8 review procedure is especially limited, as the supervisory body is entitled to terminate reviews before they start, without giving detailed reasons, on the grounds that the situation is “not reviewable”. Not surprisingly, requests for review from relatives appear so far to have been very rare; only 68 requests from representatives were made in the first nine months, one for every 34 authorisations, and responses suggested that most of these would have been from paid representatives. There were also accounts of relatives being turned away on spurious legal grounds or without being given adequate reasons.

Failing a satisfactory response to a request for a review, the only option open to the representative is to apply to the Court of Protection. The Government has gone to some lengths to ease this process, at least in respect of appeals against detention, by providing a fast-track and non-means-tested Legal Aid, but the hearing centres are still very distant for many people and it is likely that most cases will be dealt with on paper only. It will also be much more difficult for representatives to frame a credible application to the court if the supervisory body has failed to provide detailed reasons for its refusal to

review. In addition, the inability to present their case in person will put detained persons and family representatives at a great disadvantage relative to the supervisory bodies and managing authorities, which will find it much easier to assemble statements of case and professional reports. In terms of accessibility, this process is in no way comparable to the tribunal system under the Mental Health Act.

Not surprisingly, therefore, it appears to have been little used so far, and the respondents were aware of only a handful of cases in progress or being considered. By the Government's own estimate there should be about 80 applications to the court in the first full year, but even if this is achieved it will still be a tiny volume of cases relative to the Mental Health Act system which would generate about 1,000 tribunal applications per year from the same number of detentions. It will certainly *not* be achieved unless lawyers become involved, but although the Government assumed in its impact assessment that 25 per cent of those detained would consult one, directly or through their representatives (ie, about 770 people per year at the present authorisation rate), the overall impression is that consultations have as yet been very few.

This will continue to be the case if detained persons and their family representatives lack professional advice and support, and the statute does recognise that without it they may well have difficulty in initiating reviews or appeals. Section 39D provides that:

"The supervisory body must instruct an IMCA in any case where it has reason to believe that, without the help of an advocate, (the detained person and their representative) would be unable to exercise one or both of the relevant rights (to apply to a court and to apply for a review) ...have each failed to exercise a relevant right when it would have been reasonable to exercise it ...are each unlikely to exercise a relevant right when it would be reasonable to exercise it."

The responses suggest that IMCAs are far more likely than family representatives to recognise when legal processes are not being properly followed, and to challenge them, but IMCA providers reported that requests for 39D IMCAs were very rare, and it was suggested that they were being appointed in less than five per cent of cases where relatives or friends were acting as representatives, the usual practice simply being to inform the representative in their appointment letter that the service was available if they requested it. Cost (which the Government's impact assessment did not specifically provide for) may well be a factor, and it was suggested also that the volume of paperwork and notifications accompanying an authorisation was a disincentive for supervisory bodies to undertake any additional tasks which were not an absolute requirement. However, the implication is that the requirements of Section 39D are generally being disregarded and that the vast majority of family representatives are receiving no support in grappling with an opaque and impenetrable system.

“Having to share all information does not agree with good dementia practice. We should be able to determine if providing the detained person with a copy of the authorisation is inappropriate.”

“The requirements from the Act mean that the forms aren’t necessarily very easy to understand; eg, by unpaid representatives if they aren’t very well educated... I think that the DH leaflets (other than the easy-read versions) are not very well written but I do send them out as I don’t want to risk putting my own interpretation on information.”

“I am not convinced that a family member acting as representative (and with no prior knowledge of the MCA or DoLS) would have been successful in getting a review.”

“Older people with dementia have been admitted to hospital due to a physical event and have been prevented from returning home by DoLS authorisations despite the 100 per cent willingness of their carers (relatives who are spouses or sons/daughters) to provide care. In each case the caring relative has been denied representative status which leads to a complete blackout of all information and ability to challenge decisions.”

“I am concerned that there should be reviews for some people being deprived of their liberty, or that conditions not being met should be being challenged, but this is not happening. This might be because representatives don’t understand their role, or because they are intimidated by the process/professionals/ managing authority/ supervisory body... In any event the representative is a very important safeguard for the individual while an authorisation is in place, and if they are unaware of their responsibilities they cannot provide this safeguard effectively. Clearly, a way to support these representatives without intimidating them needs to be found.”

Taken from feedback to an MHA survey, 2009

Conclusions

It is still early days for DoLS, and it could not reasonably be expected that such a radically new scheme would work flawlessly from the outset. However, although the picture of what is happening on the ground is not yet entirely clear, some worrying trends do seem to be emerging and need to be closely monitored.

There have undoubtedly been positive benefits for vulnerable patients and residents. These have been both direct, as a consequence of authorisations being granted which have given them greater legal protection and brought closer external monitoring of their care arrangements; and indirect, as a result of unnecessary restrictions being removed following an assessment, or more generally as a result of heightened awareness amongst care providers and their staff and consequent improvements in their practices.

However, it must be asked whether many of these gains could have been achieved more cost-effectively by other means, it being apparent that a great deal of professional time is being expended not in working directly with vulnerable individuals but in grappling with the rigid, over-detailed procedures and with the huge volume of paperwork which they generate. This would be more acceptable if it could be shown that such complex procedures are necessary to prevent abuses of power, but many of them seem to be complex for their own sake while at the same time they fail to provide the necessary checks and balances. The Part 8 review procedure in particular runs to 24 impenetrable paragraphs, yet is still not an effective mechanism by which detained persons or their representatives can challenge an authorisation, and in view of a recent High Court judgment (*Salford City Council v BJ*, 2009 EWHC 3310) it must be doubtful whether it is compliant with Article 5(4) of the ECHR.

Although many people believed it to be unrealistically low, there is no reason at this stage to question the validity of the Government’s prior estimate of the number of cases for which an authorisation would be justified. However, the fact that the level of applications so far has been much lower even than this is most unlikely to reflect the

success of supervisory bodies and managing authorities in eliminating unnecessary deprivation – for that to be a credible explanation there would need to be much more evidence that awareness and understanding of the Mental Capacity Act and of DoLS has penetrated to every corner of the care system. Rather, it is more likely to reflect a continuing high degree of misunderstanding and resistance on the part of care providers, a poor understanding of the basic MCA and the negative connotations of the word ‘deprivation’ being highlighted by a number of respondents.

This may be overcome, given time and continued educational effort on the part of supervisory bodies and the Government. More worrying is the evidence of very great disparities in application rates between comparable supervisory bodies. This may in part reflect widely differing levels of investment in education and awareness-raising, and also different policies, some of doubtful legality, in respect of the screening of applications or potential applications, but it seems likely that the major reason is that ‘deprivation of liberty’ is very ill defined and therefore subject to a very wide range of local interpretations.

This was obvious even prior to 1 April, when the forecasts of likely cases from supervisory bodies of similar size, and based on the same guidance, varied from single figures to many hundreds, and it is apparent now in the frequent reports of disputes between managing authorities, CQC inspectors, IMCAs and assessors as to whether a particular situation amounts to deprivation. The Government’s position is that the meaning of the term will eventually be clarified by the accumulation of case law, but as every judicial finding is “specific to the facts of the case” and very few cases are getting to the higher courts, this may take many years. In the meantime, care providers cannot know with any degree of certainty whether they are acting within the law, and equally, they have no grounds to be as confident as some of them seem to be that they are *not* acting outside it.

More thorough training of assessors would not in itself resolve this problem, since the root cause is the vagueness of the guidance in the Code. However, better training would assist their understanding of, and compliance with, the letter of the procedures, and this can be done by ensuring that the annual ‘refreshers’ they are required to undertake are much more than a nominal exercise. In addition, if the numbers of applications remain low it should be possible, the ‘suitability’ requirement permitting, to reduce the number of assessors and thereby ensure that those who remain have adequate experience and knowledge.

There is also very little incentive at present to improve the level of procedural compliance, since the likelihood of any legal challenge is minimal. The safeguards depend far too much on family representatives who may be elderly or disabled themselves, and there is far too much scope for supervisory bodies to protect their actions from scrutiny by selecting representatives who agree with them, by removing those who do not, or by failing to provide them with enough information or support and batting away requests for review. The Court of Protection is also inherently unsuitable as a route for appeals, and the process is heavily weighted against family members and in favour of the bodies which support the detention.

Although the flaws in the safeguards are fundamental, and raise questions at several points about compliance with Articles 5 and 6 of the ECHR, they could nevertheless be substantially ameliorated in practice by the greater involvement of IMCAs, who are the only people independent of the supervisory bodies and managing authorities with the expertise to mount effective challenges. This may in part be an issue of resources, but their current level of participation is far below what was anticipated, and there should therefore be scope to increase it substantially.

Recommendations

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. While 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 case law 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.

Mental Health Alliance members

Afiya Trust; Black Mental Health UK; British Association for Counselling and Psychotherapy; British Association of Social Workers; Caritas Social Action; Ethnic Health Forum North West; Hafal; Institute of Mental Health Act Practitioners; King's Fund; Manic Depression Fellowship; Mental Health Foundation; Mind; National Autistic Society; NUS; Witness; Rethink severe mental illness; Revolving Doors Agency; Richmond Fellowship; Royal College of Psychiatrists; SANE; The Sainsbury Centre for Mental Health; SIRI; Together; Turning Point; UK Federation of Smaller Mental Health Agencies; UKAN; UNISON; United Response; Voices Forum; YoungMinds; The 1990 Trust; African Caribbean Community Initiatives; Age Concern England; Alcohol Concern; Association of Directors of Social Services; AWAAZ (Manchester); AWETU; British Medical Association; BME Mental Health Network; Carers UK; Church of England Mission and Public Affairs Council; Confederation of Indian Organisations; Democratic Health Network; Depression Alliance; Drugscope; East Dorset Mental Health Carers Forum; Family Action; Footprints (UK); General Medical Council; Haldane Society of Socialist Lawyers; Having a Voice; Homeless Link; Imagine; JAMI; Justice; Law Society; Liberty; Local Government Association; Manchester Race and Health Forum; Mencap; Nacro, NHS Confederation; Race on the Agenda; RADAR; Refugee Action; Royal College of General Practitioners; Sign; Social Action for Health; Social Perspectives Network; Somali Mental Health Project; Supporting Carers Better Network; UK Council for Psychotherapy; West Dorset Mental Health User Forum; WISH.

Please contact the Mental Health Alliance with any enquiries about this report:

Mental Health Alliance, c/o Richmond Fellowship, 80 Holloway Road,
London N7 8JG

www.mentalhealthalliance.org.uk

The following organisations can provide information and advice about the
Deprivation of Liberty Safeguards:

Counsel and Care

National charity working with older people, their families and carers to get
the best care and support. We provide personalised, in-depth advice and
information, which informs our research and campaigning work.

Contact our confidential Advice Line on:

0845 300 7585 (local call rate)

Monday to Friday, 10.00am to 4.00pm

except Wednesdays, 10.00am to 1.00pm

www.counselandcare.org.uk

Counsel and Care, Twyman House, 16 Bonny Street, London NW1 9PG

Mind

Mind's Legal Advice Service provides information and advice on mental health
related law covering mental health, community care, capacity, discrimination/
equality and human rights. It is primarily for members of the public, including
people with mental health problems and their families, and advocates
representing their interests.

Contact the Legal Advice Service on:

0845 225 9393 (local call rate)

Monday to Friday, 9.00am to 5.00pm

legal@mind.org.uk

Mind LAS, PO Box 277, Manchester M60 3XN



Mental Health Alliance