
The Deprivation of Liberty Safeguards – essential protection or bureaucratic monster?¹

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The background

The Deprivation of Liberty Safeguards (DoLS), which came into force on the first of April 2009 as an amendment to the *Mental Capacity Act 2005*, are still commonly referred to as the “Bournewood safeguards,” but in fact the concern about the underlying issue long predates the final decision of the European Court of Human Rights on the *Bournewood* case. It goes back at least to 1983, when the new Mental Health Act brought in much greater protection for patients who were formally detained in hospital, and in particular for those who lacked the capacity to consent to treatment and who acquired additional safeguards under Part IV of that Act. However, this in turn highlighted the total absence of protection for those patients without capacity who were “*de facto* detained” under the common law.

I was one of the first Mental Health Act Commissioners, and I can well remember in the mid-1980s visiting large, remote learning disability hospitals some of which still had several hundred patients. Our remit extended only to those formally detained under the Act, who in such hospitals were usually less than 5% of the total, but it was clear to us that the situation of the other 95% was not materially different – all were subject to the same institutional regimes and had minimal control over their own lives, and there was no question that they would be prevented from leaving if they attempted to do so. Nor did most of them have family, friends or social workers outside who could safeguard their interests, and as they had no right of appeal to a tribunal they could not benefit from the post-1983 extension of Legal Aid to tribunal hearings, which was then fuelling an explosion of legal activity in respect of those who were formally detained.

One such patient was HL, who had been at Bournewood Hospital in Surrey since 1962. However, in 1994 he was discharged into the care of professional family carers, and when he was readmitted in 1997 to the “intensive behavioural unit”, and *de facto* detained, they had the ability and the determination to mount a legal challenge on his behalf, which in 2004 established that reliance on common law was incompatible

¹ This paper is an expanded version of the one given to the Law Society Mental Health Conference in April 2009

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with Article 5 of the ECHR.³ In 2005 the government consulted as to the best way to remedy this incompatibility, and the prevailing view was that this should be by extension of the *Mental Capacity Act* rather than the *Mental Health Act*.⁴

A lack of Parliamentary scrutiny

So far, so good – there was general agreement both about the need for new powers and about the most appropriate vehicle for them. However, this is where things began to go wrong. There should by then have been a new Mental Health Act, but the government had been forced to abandon not one but two draft Bills, a situation without precedent, and in March 2006 it decided to introduce, on a very tight timescale and with minimal consultation, a Bill to amend the existing Act. It then further decided to tack the deprivation-of-liberty amendments to the *Mental Capacity Act* onto the end of it.

This had a number of consequences. First of all, the preparation of the definitive DoLS proposals, and the consultation on them, had to be telescoped to fit the timetable of the Mental Health Bill, and the senior government lawyers were no doubt preoccupied with Community Treatment Orders (CTOs) and “appropriate treatment” and do not appear to have exercised sufficient oversight of the drafting of the two new Schedules to the *Mental Capacity Act*, A1 and 1A, which are the core of DoLS. At the time of the first stakeholder consultation meeting in September 2006 the scheme appeared to be still in a very raw and unsatisfactory state, with much unnecessary complexity, but we were told that the Schedules had already been “signed off” to go into the Bill and could be amended only in detail; and indeed, we did not even get sight of them until the Bill was published in November 2006, only two weeks before its Second Reading in the Lords.

To be fair to the officials concerned, they were far more receptive to advice than their Mental Health Bill colleagues down the corridor, who appeared to be under instructions to resist all amendments however sensible, and they did their best to compensate for the deficiencies in the Schedules by incorporating our suggestions into the Regulations and the Code of Practice⁵, which were first shown to us in very early drafts. However, this inevitably added to the complications, and it introduced inconsistencies between the Schedules and the Code which are now becoming apparent as practitioners begin to grapple with them. In addition, it was not possible to address fully the issue of the relationship between DoLS and the *Mental Health Act*, since the officials had assumed at the outset that there would be only minimal overlaps of the populations affected, the powers themselves and the personnel operating them, and it appeared only gradually to dawn on them that the interactions between the two schemes would be both substantial and complex.

In theory, this could all have been put right in Parliament, but the Mental Health Alliance was equally preoccupied with CTOs and “appropriate treatment”, and as the lead on the Bill for the British Association of Social Workers (BASW) my priority had to be the Approved Mental Health Professional and the issues related to it. It would not, in any case, have been possible to remedy the defects in the Schedules by a few selective amendments, and in BASW’s Parliamentary Briefing I said that “their complexity is completely disproportionate to the nature of the powers involved, and would be a considerable burden on those required to understand and to implement them ... the draft Schedules

3 *HL v United Kingdom* (2004) 40 E.H.R.R. 761

4 *Protecting the Vulnerable – the Bournewood consultation – summary of responses – Department of Health June 2006*

5 *The DoLS Code of Practice, issued by the Ministry of Justice in August 2008, is a supplement to the main Mental Capacity Act Code “and should be used in conjunction with it.”*

should be withdrawn and the whole scheme should be drastically simplified, paying particular attention to the need to ensure compatibility with the Mental Health Act.”

However, in the context of the war of attrition which was then going on between the Alliance and the government, absorbing all available time in both Houses, there was no possibility that this message would be heeded, and so, apart from a brief consideration by the Joint Committee on Human Rights,⁶ the Schedules passed into law unscrutinised and unamended.

A scheme for hospitals rather than care homes

What we have, therefore, is a scheme which was generally supported in principle but which is severely defective in detail. These defects arise, first of all, from the government’s determination to base it around the *Bournewood* case, despite this being very untypical of the circumstances in which the new power is likely to be needed.

Bournewood Hospital has now closed, as have almost all the other long-stay hospital units for people with learning disabilities. Long-term care for people with any kind of mental disorder is now provided almost entirely outside the hospital system, and this has had an enormous impact on the population of care homes. Even 20 years ago, few care homes would accept residents with an appreciable degree of dementia, but now in England alone there are about 150,000 residents with this diagnosis in homes for older people, 40% of all residents.⁷ People with learning disability and challenging behaviour, or people with behaviour disturbance due to an acquired brain injury are also cared for almost entirely outside hospital, and increasingly even outside the care home system in high-support housing schemes where the care staff are provided by a registered domiciliary care agency.⁸ The potential for deprivation of liberty *outside* hospital (and even outside the DoLS scheme, which applies only to hospitals and care homes) has therefore greatly increased.

At the same time, the need for any new power within hospitals has greatly *decreased*. Hospital admissions are increasingly short-term and for acute treatment only, and the *Mental Health Act* is used much more frequently than hitherto – between 1996 and 2006 the rate of detention increased by 20% whilst the number of beds declined by 29%, with the result that around 36% of in-patients are now detained at any one time.⁹ Indeed, anyone with a learning disability being admitted to a specialist hospital unit for management of disturbed behaviour in similar circumstances to those of HL in 1997 would very probably now be detained under the *Mental Health Act*, as was HL himself when his *de facto* detention was challenged. There are very few circumstances in which an in-patient receiving treatment for mental disorder could be detained under DoLS but not under the *Mental Health Act*, and there are a number of cogent reasons, set out by Richard Jones in the preface to the 11th edition of his *Mental Health Act*

6 See later references

7 *The State of Social Care in England 2007–8, Commission for Social Care Inspection January 2009, paras 4.16, 4.21*

8 *A care home is defined in Section 3 of the Care Standards Act 2000 as one which provides “accommodation together with nursing or personal care”. High-support housing schemes also provide nursing or personal care, but the care is supplied by a domiciliary care agency as defined in Section 4(3) of that Act. Both must be registered with the Care Quality Commission under Section 11. To the uninitiated observer, many high-support housing schemes are indistinguishable from care homes, and are arguably no less likely to be depriving residents of their liberty, but are outside the DoLS scheme.*

9 Keown, P. et al *A retrospective analysis of hospital episode statistics, involuntary admissions under the Mental Health Act 1983, and the number of psychiatric beds in England 1996–2006, British Medical Journal 2008;337:a1837*

Manual¹⁰, as to why the *Mental Health Act* should be preferred, in particular that the procedural safeguards are much greater.¹¹

Although in its initial consultation the government did acknowledge that “there is the potential for people to be deprived of their liberty in care homes as well as in hospitals”,¹² when we first met the officials in 2006 to discuss the detailed scheme their thinking was still very hospital-oriented. This was perhaps understandable in that hospitals were what they knew – the Department of Health deals directly with them, whereas the care home sector has historically related primarily to the local authorities and the social care regulator – but it has had the consequence that the nature of the scheme is basically unsuited to the sector in which the majority of cases are likely to arise.

The responsibility for recognising that deprivation of liberty is taking place, and of applying for an authorisation, rests with the “managing authority”, that is the hospital or the care home.¹³ This should be a straightforward task for psychiatric hospitals, which have staff who are very familiar with the legal issues around capacity and detention, plus a substantial underpinning of management, regulation and legal advice, but the care home sector is very different. There are approximately 20,000 care homes in England and Wales,¹⁴ the majority of which are small independent organisations in which the proprietor is often a hands-on carer. Proprietors and managers frequently have minimal knowledge of mental health and mental capacity law, and many have no ready access to legal advice or training.

This was noted by the Parliamentary Joint Committee on Human Rights, which said “ In *HL v United Kingdom* the Court held (at para 114) that ‘an important ingredient of lawfulness is that all law must be sufficiently precise to allow the citizen – if need be with appropriate advice – to foresee, to a degree that is reasonable in the circumstances, the consequences which a given action might entail.’ The proposals to amend the *Mental Capacity Act* are detailed and complex, and we question whether they will be readily understood by proprietors of residential care homes, even with the benefit of professional advice.”¹⁵

Moreover, over 30% of care home residents in England are self-funding,¹⁶ and many homes take no publicly-funded residents at all and so have no contractual relationships with the Primary Care Trusts and local authorities who are the supervisory bodies for DoLS. In addition, homes with high quality ratings may now be inspected by the regulator, the Care Quality Commission (CQC), only once every two or three years. The logistics of informing and educating them about the new provisions, and of monitoring their compliance with them, are therefore formidable – in Kent, for instance, there are 16 mental health hospitals but 723 registered care homes.¹⁷

10 Jones R.M, *Mental Health Act Manual 11th Edition*, Sweet and Maxwell 2008

11 And this position appears now to have been strongly reinforced by the judgement of Charles J in the GJ case ((2009) EWHC 2972 (Fam) 20th November 2009)

12 “Bournemouth” Consultation, Department of Health March 2005 para 4.2

13 *Mental Capacity Act 2005*, Schedule A1 Para 24

14 *The State of Social Care in England 2007–8*, Commission for Social Care Inspection ; *Annual Report 2007–8*, Care

and Social Services Inspectorate Wales

15 Joint Committee on Human Rights, *Legislative Scrutiny, Mental Health Bill*, 4th Report of Session 2006–7, HL Paper 40/HC 288, para 90

16 *The State of Social Care in England 2007–8*, *ibid* (note 6 above), based on Laing and Buisson’s *Care of Elderly People Market Survey 2008*. This is an estimated average; in wealthier parts of the country it may be over 60%.

17 CQC *Directory of Care Homes and Care Services and Healthcare Services Directory*, at www.cqc.org.uk

The guidance (or lack of it) on deprivation of liberty

The guidance from the government then tells the managing authorities that “deprivation of liberty in a hospital or care home should be a relatively rare occurrence, therefore only a small number of people should need a DoLS authorisation.”¹⁸ Whether or not it is true, this statement is likely to become a self-fulfilling prophecy; if you are a care home proprietor with little understanding of the legal issues and are reluctant to fill in the standard application form, which runs to 12 pages asking 34 separate questions,¹⁹ some of which you don’t fully understand, so that assessors can come and question the way you care for your residents, it will be easy to convince yourself that whatever deprivation of liberty is, if it’s a rare occurrence then it surely can’t be happening in *your* home.

This tendency will then be reinforced by the vagueness and inconsistency of the official guidance. The government told the Joint Committee on Human Rights that it was “not possible” to provide a statutory definition, since the distinction between a restriction on liberty and a deprivation of liberty “was a matter of degree rather than substance”,²⁰ and it says in the Code that “the question of whether someone has been deprived of liberty depends on the particular circumstances of the case” and that “the question of whether the steps taken ... in relation to a person amount to a deprivation of that person’s liberty is ultimately a legal question, and only the courts can determine the law.”²¹

It has, nevertheless, given advice on identification, but this has varied from document to document – for instance, its guidance to supervisory bodies in the Implementation Tool issued in April 2008²² is quite significantly different to that in the Code issued four months later. Its subsequent guidance to managing authorities is based on the Code, but is again not identical to it, and there seems to be no awareness that small differences in wording can make a big difference to the way in which phrases are interpreted by staff on the ground – for instance, “a significant period” in the Code becomes “a long period of time” in the guidance to managing authorities.

The Code is, however, the definitive document to which all parties are required by law to “have regard”²³, and it lists seven factors which it says, very tentatively, “can be relevant to identifying whether steps taken amount to a deprivation of liberty.”²⁴ Several of these factors are, however, no more than very general statements, useful for stimulating discussion in a case conference or as the starting-point for a legal argument but open to too many interpretations, and of little help in closing down discussion and reaching a decision as to whether or not to make an application, which is what managing authorities are required to do.

For instance, the statements that “staff exercise control over assessments, treatment, contacts and residence” and that “the person loses autonomy because they are under continuous supervision and control” could arguably apply to any regime which is providing a very high level of care for people, such as those with severe dementia, who totally lack the ability to make decisions for themselves and who would be at high risk if not continuously supervised. These criteria can be properly understood only with an understanding of the caselaw from which they are derived, but it is not reasonable to expect a care home manager to possess this.

18 *Deprivation of Liberty Safeguards – a guide for hospitals and care homes*, Department of Health/Office of Public Guardian OPG608 February 2009, page 11

19 *Standard Form 4*. In February 2009 the Department of Health issued standard forms and letters for the use of managing authorities and supervisory bodies. These are non-statutory, but reflect closely the requirements of the Schedules and Regulations.

20 *Joint Committee on Human Rights*, *ibid* (note 15 above) para 84

21 *DoLS Code of Practice*, *ibid* (note 5 above) Chapter 2

22 This was guidance from the Department of Health to the Local Implementation Teams to enable them to estimate the likely need for authorisations in their areas.

23 *Mental Capacity Act 2005* Section 42(4)

24 *Code* para 2.5

When in doubt about their legal duties, care homes tend to look to the regulator, now the CQC, but the guidance it has issued to them²⁵ will further compound the problem. It contains yet another set of variations on the Code, and it makes a number of assertions which go beyond what is said in the Code or which could reasonably be inferred from current caselaw. In particular, it says that “a decision about any one thing is unlikely to mean that someone is being deprived of their liberty” (so it might be lawful to chain them in the cellar unless it was also decided to bar their relatives from visiting them there!) and that “periodically restraining someone in order to give them vital care or treatment ... does not alone amount to them being deprived of their liberty”.

The issue as to how frequently and how severely restraint can be applied under the protection of Section 6 of the *Mental Capacity Act* before it amounts to deprivation is an extremely grey area, and in the absence of caselaw the Code (para 2.12) correctly treads very warily – “where the restriction or restraint is frequent, cumulative and ongoing, or if there are other factors present, then care providers should consider whether this has gone beyond permissible restraint.” The CQC variation on this, however, is that “where restraint is used frequently *and* (my italics) other decisions have been taken that significantly restrict a person’s liberty, services should consider whether the person’s liberty is being deprived” (sic). Reading this, a home manager might well be reassured, falsely in view of the lack of caselaw, that frequent use of restraint does not raise a question of deprivation unless other restrictions are also being applied.

An alternative approach

Richard Jones, in the 3rd edition of his *Mental Capacity Act Manual*, has also produced guidance based on the caselaw, but his is more detailed and specific and includes 20 factors which he has divided into two lists, the first being of factors at least one of which would, in his view, need to be present for a court to find deprivation, and the second being of factors which by themselves would amount only to restriction on liberty.²⁶ For instance, where the Code says simply that deprivation may arise “if staff exercise complete and effective control over the care and movement of a person for a significant period,” Jones lists the following factors as likely to point to deprivation:

- Force or threats being used to prevent the person from leaving the hospital or care home in a situation where the person is making a persistent and/or purposeful attempt to leave
- Sedation being used to prevent the person from making an attempt to leave the hospital or care home
- The patient’s access to the community being denied or severely restricted primarily due to concerns about public safety

And the following factors as likely in themselves to point only to restriction:

- The person being treated or cared for in a locked environment
- The design of door handles or the use of key pads making it difficult for a confused person to leave the hospital or care home
- Staff bringing a person who has wandered back to the hospital or care home

25 MCA DoLS; guidance for CQC staff and providers of registered care and treatment services, *Care Quality Commission* 074/09, May 2009.

26 Jones, R. *Mental Capacity Act Manual 3rd Edition*, Sweet and Maxwell 2008, 2-006. Revised lists have been incorporated in Part 6 of the 12th Edition of his *Mental Health Act Manual*, published in October 2009

- Dissuading a confused person from attempting to leave the hospital or care home, using benign force if necessary; this would be the case even if they had attempted to leave the premises on more than one occasion
- A temporary refusal to let the person leave the hospital or care home in the absence of an escort whose role would be to support the person rather than to protect the public.

Lawyers may argue about the validity of particular factors, but the basic approach is sound; my experience in training is that front-line practitioners, including care home managers, can relate these factors much more easily to real-life situations than the seven points in the Code, and that when they have been taken through them they are much more confident that they can recognise when deprivation is taking place, and of equal importance, when it is *not* taking place. This tends to confirm the view of the Joint Committee on Human Rights that “deprivation of liberty is a less flexible and elusive concept than might be thought from the draft illustrative guidance.”²⁷

The scheme will not begin to work properly, therefore, until the government is prepared to issue much more specific guidance which makes practical sense to staff in care homes, and perhaps not even then until it is backed up by positive action by the CQC to identify possible unlawful deprivation.²⁸ However, the CQC’s monitoring programme, for 2009–10 at least,²⁹ will focus almost exclusively on cases where applications have already been made and of ensuring compliance with procedures thereafter, and there is no suggestion yet that its inspectors will pro-actively seek out cases where applications should have been made but have not been.

In the meantime, it is perhaps not surprising that applications have been very slow to materialise. By the end of the first six months, 4068 had been made, a third of what the Department of Health had expected in that period, and leading to around 1550 authorisations³⁰, even though many with experience “on the ground” felt the Department’s annual forecast³¹ to be a serious under-estimate of the true level of deprivation.

Unnecessary bureaucracy

If applications do remain at a low level, however, the second major defect of the scheme will perhaps not matter so much. The government on its DoLS website says that the safeguards “are designed to protect the interests of an extremely vulnerable group of service users whilst avoiding unnecessary bureaucracy” but that’s a government target which has most definitely been missed. Richard Jones sums it up very well – “a procedure has been created that is hugely complex, voluminous, overly bureaucratic and difficult to

27 Joint Committee on Human Rights, *ibid* (note 15 above) para 86

28 In England, the Mental Capacity (Deprivation of Liberty: Monitoring and Reporting) Regulations 2009 give the Care Quality Commission powers to monitor the operation of DoLS in both hospitals and care homes. In Wales there are no regulations, but the Welsh Ministers “have provided that as part of their regular inspection processes” DoLS will be monitored by the Health Inspectorate Wales (HIW) and the Care and Social Services Inspectorate Wales (CSSIW). In England, monitoring of DoLS in care homes will for the time being be incorporated into the existing inspection and quality assurance processes which the CQC inherited from the Commission for Social Care Inspection.

29 CQC guidance for staff and providers, *ibid* (note 25 above)

30 Six-month outturn figures (to 30th September 2009) announced on 5th November 2009 by Paul Gantley, National Programme Implementation Manager for the Mental Capacity Act, at the Community Care conference on Safeguarding Vulnerable Adults.

31 Regulatory Impact Assessment, May 2008. This assumed 21,000 assessments in the first year, leading to 5,000 authorisations, but with a peak in the first six months. Many local surveys carried out on the basis of the government’s own Implementation Tool produced estimates of at least double these figures.

understand, and yet provides mentally incapacitated people with minimum safeguards... the fact that key elements of the *Mental Capacity Act* have been rendered largely incomprehensible to both lay people and to many professionals represents a significant failure on the part of both government and Parliament.³²

The Schedules consist of a total of 205 paragraphs, and there are then a further 40 regulations, and all this to define a single, simple power. It is not just the length of the Schedules which makes them so impenetrable, but their obscure language, their relentless over-specification of detail, and their convoluted structure which makes it impossible to find the answer to any question in any one place. The convolutions are such that they may even in some places have defeated the drafters, as practitioners who follow them are now finding themselves in legal cul-de-sacs from which there is no rational line of escape.

As a result, the Code of Practice is not what is conventionally understood by that term, but is largely a summary of the Schedules and Regulations in plain English. It does not even attempt to cross-reference to the Schedules as that would be virtually impossible, so those reading it have no idea what is statute and what is simply guidance, or whether the guidance is consistent with the statute. In some places it is not – for instance, at 3.17 it advises supervisory bodies that on receipt of an application they must “consider whether the request is appropriate and should be pursued” but the Schedule makes no provision for any such screening-out process.

The incomprehensibility of the statute has had a number of consequences, the first of which is that most of the assessors and managers in the supervisory bodies who will be applying the safeguards have been trained entirely on the basis of the Code, and very few have seen the Schedules or even have access to a copy of them. The Code is, however, no more than a summary, and not always an accurate one (for instance, although it purports to apply to Wales it is, because the Welsh Assembly made its own Regulations after it was published, now incorrect for that country at 14 points, of which only 8 have been highlighted in subsequent guidance.)³³ It also uses different language, which may be legally significant – for instance, although the Schedules describe the relevant person as being a “detained resident”,³⁴ the Code only once uses the word “detained,” and that is hidden away in an appendix.³⁵ The dangers, when operating legislation involving deprivation of liberty, of relying on a summary alone will no doubt be apparent to readers of this journal.

A second consequence is that there are in England 36 standard forms and letters running to 188 pages, and the best-interests assessors, to do everything that might fall within their remit, would need to complete 13 of them.³⁶ The Welsh have cut the length of the forms by nearly two-thirds, no doubt with the very laudable intention of reducing the burden on the assessors, but it may have the opposite effect – the saving grace of the English forms is that they do follow the Schedules very closely, and so the assessors can simply answer the questions and tick the boxes without needing to know very much about the underlying statute.

32 *Mental Capacity Act Manual 3rd Edition, ibid, (note 26 above) Preface*

33 *Guidance for Supervisory Bodies / Guidance for Managing Authorities, Welsh Assembly Government, February 2009.*

34 *Schedule A1 Para 6*

35 *Code page 114*

36 *A best-interests assessor may be qualified to carry out up to five of the six assessments, plus the “third-party consideration” assessment, and might also complete forms on behalf of the supervisory body.*

A serious omission

The most serious weakness of the Schedules, however, is that although they are incredibly prescriptive and rigid in respect of peripheral matters which could largely be left to discretion, they are completely silent on a number of issues of substance. In particular, they fail to ensure that the power granted to the managing authority is precisely defined, or to ensure that its use is closely monitored, and they therefore leave the way open for abuse of that power.

The Regulations require the managing authority, but only “if they are available or could reasonably be obtained,” to include on the application form “details of the proposed restrictions on the relevant person’s liberty.”³⁷ If these details *are* provided, the best interests assessor will no doubt address them, although the Code makes no reference to this and simply directs the assessor to “examine any relevant needs assessments and care plans prepared for the person,” this being the sole requirement in the Schedule.³⁸ The unstated assumption appears to be that the care plan will be the main source of the detail of the restrictions which the managing authority is placing or proposes to place on the person’s liberty – “the assessor must consider whether the care plan and the manner in which it is being, or will be, implemented constitutes a deprivation of liberty.”³⁹

The standard (but non-statutory) form then requires the assessor to give their opinion as to whether “the proposed arrangements” are in the person’s best interests.⁴⁰ “Proposed arrangements” is however, not a term which appears in either the Schedule or the Code, nor is there any requirement for the assessor to spell out what they understand those arrangements to be or in which document they are to be found, and it is no more than an assumption that the term refers to the restrictions which are supposedly set out in the application and/or care plan (but which need not be).

If that is the case, then it also assumes that the assessor has approved those arrangements as they were originally presented. However, one of their duties is to ensure that the person’s liberty is restricted to the least extent necessary, even if this still amounts to deprivation of liberty,⁴¹ and they may therefore insist on changes to the arrangements before they are prepared to agree that they are in the person’s best interests. The restrictions which the assessor thinks are acceptable may therefore not be those set out in the application form or the care plan, but the Code does not acknowledge that there may be a process of negotiation, and appears to envisage that the assessor will simply say yes or no to whatever was initially put forward by the managing authority.

The negotiations may in any case be academic, since where an authorisation is given without conditions, there is nothing in the Schedules which requires the managing authority to abide even by the arrangements which it originally put forward, let alone by any revised version agreed with the assessor, and it can therefore institute restrictions over and above those which the assessor regarded as being in the person’s best interests. This can be prevented by defining the “proposed arrangements” which were agreed by the assessor and then imposing a condition that they be adhered to, but the Code fails to advise that this should be done or to warn of the possible consequences of not doing so.

37 *Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008 Regulation 16 (2) (f)*

38 *Schedule A1 Para 39 (2) (b-c)*

39 *Code para 4.63*

40 *Standard Form 10, question D6 (see note 19 above)*

41 *Since their assessment is governed by the 6th principle in Section 1 of the Mental Capacity Act, that “before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person’s rights and freedom of action.”*

If no such condition is made at the outset, the supervisory body may then find it difficult to impose one retrospectively, as Schedule A1 prohibits this unless there has been “a change in the person’s case,”⁴² and there is arguably no change simply because the managing authority did not do something which the assessor and supervisory body thought it would do but which it was not actually required to do. Nor is there any statutory mechanism to ensure that the supervisory body *knows* that the managing authority hasn’t done it. Although the Schedule spells out the review procedure in eye-watering and totally unnecessary detail, there is no requirement in either the Schedules or the Code that the supervisory body should monitor closely after an authorisation has been given so that it knows when a review is needed. In those cases where it is also the commissioner of the care, that should happen anyway through the normal processes of care management, but it is yet another unstated assumption that it will maintain oversight in other cases.⁴³

Who will safeguard the Safeguards themselves?

In fact, the only individual with a statutory duty to maintain contact with the detained resident is their representative, and the government has placed great emphasis on this role as being the primary safeguard and has included a number of specific duties in the Regulations.⁴⁴ However, in most cases the representative will be an unpaid relative or friend – in England there is no power even to pay expenses. The supervisory body does have discretion to appoint a paid representative if the best-interests assessor declines to nominate an unpaid one, but there must be concerns that, although it is technically neutral as between the managing authority and the assessors – who act as “independent public bodies” – it may be subject to a conflict of interest in choosing a representative if it is also commissioning the care. It is also questionable whether either supervisory body or best-interests assessor will be inclined to nominate a representative who is likely to challenge the assessor’s decision; anecdotal accounts are already beginning to circulate of “awkward” relatives being passed over, and there may well be challenges, especially from close family members who might well have been the relevant person’s own choice if they had had the capacity to make one.

Although representatives who are also relatives or friends are entitled to support from an Independent Mental Capacity Advocate,⁴⁵ they lack the powers of the Nearest Relative under the *Mental Health Act*, and their only real sanction is to apply to the Court of Protection. To its credit, the government acknowledged concerns about the accessibility of this process relative to the Mental Health Tribunal system, and at the last minute it extended non-means-tested legal aid to appeals,⁴⁶ and introduced a special “fast-track” procedure for all applications involving deprivation of liberty.⁴⁷

42 Para 107

43 *One of the basic principles of the DoLS scheme was that it would be linked to the process of care planning and management by ensuring that the body which commissioned the care was also the supervisory body, hence obviating the need for a specific oversight duty. However, this will frequently not be the case in practice because of self-funding (see note 16 above), and because Primary Care Trusts now place people requiring “continuing nursing care” in care homes where the supervisory body will be a local authority. The principle has effectively been abandoned in Wales in respect of hospitals due to the amalgamation of commissioning and provider bodies.*

44 *Mental Capacity (Deprivation of Liberty: Appointment of*

Relevant Person’s Representative) Regulations 2008, Reg. 12 (1)(a). There are separate, and somewhat different, regulations for Wales.

45 *Mental Capacity Act 2005 (as amended) Section 39D*

46 *Community Legal Service (Financial) Amendment Regulations 2009. The provision covers applications to the Court of Protection by relevant persons or their representatives under Section 21A of the Mental Capacity Act (which provides for appeals against authorisations themselves or any element of them), but it does not cover applications on other issues related to DoLS.*

47 *Practice Direction, Deprivation of Liberty Applications, March 2009 (supplement to Part 10A of the Court of Protection Rules.)*

However, the process is still cumbersome when compared to that available to those detained under the *Mental Health Act*, and it must be questionable whether it is truly compliant with Article 5 of the ECHR as being one by which “the person deprived of their liberty can have the lawfulness of their detention decided speedily by a court”. An application could not practicably be made by a representative without legal assistance, and the hearing centres will for many, be remote – for people in East Anglia the nearest is 100 miles away in London – so it will be very difficult for relevant persons themselves, or staff caring for them, or relatives who are often elderly, to attend in person, and cases will have to be decided purely on the basis of legal submissions and expert reports. The government’s own estimate is that there will be only one application for every 40 DoLS authorisations,⁴⁸ as compared to one Tribunal application for every three detentions under the *Mental Health Act*.⁴⁹

Given all this, it seems likely that despite the mountain of paperwork which DoLS authorisations are bound to create, the main beneficiaries will be the managing authorities – the hospitals and care homes – who will gain legal protection for their actions, and who may then impose restrictions on liberty with more confidence than hitherto, but with very little accountability in return.

48 *Regulatory Impact Assessment, ibid (note 31 above)*

49 *In 2007–8 there were approximately 47,000 episodes of detention under the Mental Health Act in England and Wales, and 15,605 applications to the Mental Health Review Tribunal (Mental Health Act Commission, 12th Biennial Report, 1.18 and 2.111). However, these figures cannot be related directly, as some applications will be in respect of detention commencing in previous years, and patients might not apply twice when a Section 2 is followed by a Section 3. The MHAC, at 2.113, quotes a research finding at one acute hospital that 81% of detentions commencing in 2006 were appealed.*