

# Dementia and the Deprivation of Liberty Safeguards: quick guide

Author: Tim Spencer-Lane

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## Key facts

- In 2017-18, 110,980 DoLS applications were granted in England.
- DoLS are used most often to protect older people (73% of all applications are for people aged over 75).
- Most people under DoLS have had dementia recorded as their primary disability.

Source: NHS Digital (2018)

## What are DoLS and why are they relevant to dementia?

The deprivation of a person's liberty is a serious matter. Human rights law places strict limits on when any person can be deprived of their liberty, and requires the provision of certain legal protections. The Deprivation of Liberty Safeguards (DoLS) are a means of providing protection to adults who lack the relevant capacity and are, or may become, deprived of liberty.

DoLS are part of the Mental Capacity Act 2005 (MCA). They apply to adults who have a mental health condition (this includes dementia) who are in hospitals and care homes and who lack mental capacity to being accommodated there for the purposes of care or treatment. The MCA says that someone who lacks mental capacity to make a decision cannot do one or more of the following four things because of an impairment, or disturbance in the functioning, of the mind or brain:

- Understand information given to them.
- Retain that information long enough to be able to make a decision.
- Weigh up the information available and understand the consequences of the decision.
- Communicate their decision – this could be by any possible means, such as talking, using sign language or even simple muscle movements like blinking an eye or squeezing a hand.

DoLS aim to make sure that adults in care homes and hospitals (including acute hospitals and psychiatric hospitals) are looked after in a way that respects their rights and freedom.

## More on the DoLS process

DoLS provide that an adult who lacks the relevant capacity can only ever be deprived of their liberty if doing so is in their best interests, necessary to protect them from harm and proportionate to the likelihood and seriousness of that harm.

They set out an assessment process for authorising a deprivation of liberty and a means for the person to challenge any such authorisation. Under this, care homes and hospitals (“managing authorities”) apply to local authorities or Welsh health boards (“supervisory bodies”) for authorisation to deprive a person of their liberty. The supervisory body then commissions assessments to determine whether the requirements for DoLS have been met.

Studies suggest that about 70% of residents living in care homes have dementia or significant memory problems (Alzheimer’s Society, 2015) and that more than a quarter of hospital inpatients have dementia (NHS England, 2014). So people with dementia are much more likely than any other group to be affected by DoLS.

And the report by the House of Lords select committee on public service and demographic change (2013) forecast that the number of people in England and Wales aged 65 and over with dementia would increase by over 80% to 1.96 million between 2010 and 2030.

## Case study

Mrs Brent has a diagnosis of vascular dementia. One night, the police found her wandering in the street in a confused state and very cold, so they took her to a hospital where she was admitted to a medical assessment unit.

She banged the doors trying to get out, and assaulted nursing staff. She was diagnosed as suffering from an infection, and treatment with antibiotics was started.

A referral was made for a DoLS assessment. It was established that Mrs Brent did not have the mental capacity at that time to make care, treatment or risk decisions, or to decide where she should live. The best interests assessor recommended a short-term DoLS authorisation, with conditions to enable medical and social care assessments to be concluded, and a best interests meeting to be arranged.

The assessor anticipated that following treatment for the infection, Mrs Brent’s confusion could lessen which could lead to a return home being considered.

## What is deprivation of liberty?

The Supreme Court (in a decision referred to as “Cheshire West”) has said that – in this context – deprivation of liberty means that:

- the adult lacks capacity to consent to their care and treatment arrangements, and
- they are subject to continuous (or complete) supervision and control, and
- they are not free to leave the care home or hospital.

In some cases determining whether a person is being deprived of their liberty is clear cut (see the case study below).

## Case study

Mr. Garcia is an older man with dementia, who lacks capacity to take decisions relating to his residence and care arrangements. Following the death of his wife he moved into a care home. Due to the nature of his illness, Mr. Garcia has been quite paranoid and threatening and abusive to staff. He is also very demanding with a tendency to engage in what staff call challenging behaviours. This sometimes requires the use of restraint and sedative medication. He is supervised in the home either directly by staff or via CCTV cameras.

There are not enough staff to take Mr. Garcia out every day as he has requested. He used to be a long distance walker and loses his temper and expresses frustration at not being allowed out on his own. As the home is near a main road, the manager has taken the view that concern for his health and safety demand that he should not be allowed out without one-to-one care. He says he wants to move out of the home and live on his own but staff are clear that he would not be able to manage. Mr. Garcia has clearly been deprived of his liberty.

In other cases, determining whether a person is being deprived of liberty is harder. For example, an older person might want to leave a care home but no alternative accommodation is available, or perhaps they lack the physical ability to leave the care home. In such situations it is likely that further assessment will be necessary to look at the individual circumstances of the case and decide if a deprivation of liberty is taking place.

The DoLS code of practice (paragraph 2.3) suggests it can be helpful to think a scale, which moves from “restraint” or “restriction” at one end, to deprivations of liberty at the other end. Some forms of intervention may be so restrictive that they alone constitute a deprivation of liberty, while in other cases the cumulative effect of different types of restraint may create a deprivation of liberty.

It is the amount of supervision control that the care home or hospital has over the person, as well as their freedom to leave, that determines whether a deprivation of liberty is taking place. As a rule, when considering the alternatives for care and support, “less restrictive options” should always be considered, in keeping with the requirements of the Mental Capacity Act (section 1(6)).

In deciding whether a deprivation of liberty is taking place, the following factors might be relevant – either on their own or in combination with each other:

- An adult being restrained in order to admit them to hospital or a care home.
- Medication being given without the adult’s consent during the course of the admission.
- Staff having complete control over the adult’s care or movements for a long period.
- Staff making all decisions about the adult, including choices about assessments, treatment and visitors.
- Staff deciding whether the adult can be released into the care of others or to live elsewhere.
- Staff refusing to discharge the adult into the care of others.

These factors are often relevant to the lives of those with dementia. For example, a person with dementia may exhibit challenging behaviour requiring staff to have complete control over a long period of time and to prevent them from leaving the accommodation.

However, in order to avoid the need for deprivation of liberty staff might need to ask whether enough is being done about the possible causes of the challenging behaviour – perhaps the person is experiencing physical pain which can be treated, or frightened of something that can be removed, or frustrated by the lack of something that can be provided.

People with dementia are sensitive to their environment. Living somewhere that doesn't meet their personal and emotional needs (plus their care needs) can cause significant distress. For example, for some, having access to an outside space is key to their happiness; others may have a phobia of pets and shouldn't be in a care home with them.

## When can DoLS be relevant in dementia care?

It is vital that any hospital or care home providing support for people with dementia should be familiar with DoLS. Applying DoLS in dementia care should not be seen as something separate from providing core health and social care services. The safeguards should be integral to the measures a hospital or care home must take to protect and promote the rights of patients and service users.

In particular, DoLS should not be seen as a last resort for “very difficult patients/residents”, but should be part of a continuum of positive actions taken by managers and staff to improve the person's outcomes. When used correctly, the safeguards are central to improving the experience of patients and residents whose liberty is restricted to the extent that it may become a deprivation (see case study below).

## Mental capacity

It is important to remember that DoLS only apply when someone lacks capacity to consent being accommodated for the purpose of being given care or treatment and that in dementia this lack of capacity cannot be taken for granted. Indeed, the first principle of the MCA (section 1(2)) states that a person must be assumed to have capacity unless it is established otherwise. The level of decision-making capacity depends on what stage the condition has reached and will be affected by many factors such as how the assessment is carried out and the support that is provided to do so.

It is important to be aware that the mental capacity of a person with dementia can change over time, both in the short and long term. As an example, there may be days or even times of the day when particular individuals are able to think more clearly than others, so they may have capacity at some times and lack it at others.

A person may also have the capacity to make some decisions and not others, as some decisions require them to understand more complex information, or weigh up more options. Care staff should not assume a person lacks capacity to choose what to wear or eat just because they cannot make difficult financial or medical decisions.

## Case study

Mr and Mrs Albert have been married for 66 years. Mrs Albert now uses a wheelchair and Mr Albert has early dementia and memory problems. He has been admitted for respite care to a care home, where he is thought to have some self-neglect issues. Mr Albert's social worker highlights the fact that things have been difficult at home and that, in particular, Mrs Albert has been subject to a significant amount of stress because of her husband's illness.

Both husband and wife were adamant before Mr Albert went to the care home that he should return home shortly, although there are some remaining concerns about Mrs Albert's ability to cope. Indeed, the social worker fears there might be adult safeguarding risks if he returns home without adequate support and suggests extending the placement. The extension is opposed by both Mr and Mrs Albert and a DoLS assessment is therefore initiated.

The best interests assessor discovers that Mrs Albert has been particularly worried that in the care home her husband has become sleepy and withdrawn. It turns out that Mr Albert's GP increased Mr Albert's medication while he was in the care home but now agrees to the assessor's suggestion of reducing it significantly. Within a few days, Mr Albert is assessed as having capacity to decide to return home.

Both Mr and Mrs Albert now feel more trusting of the care home regime and are agreeable to working with the social worker to help ensure a safe return home.

The social worker works with Mr and Mrs Albert to put in place an appropriate package of care to support the move home and promote independent living. Although there are clearly risks involved, the social worker is clear that the care plan is in accordance with both adults' wishes and feelings and includes provision for regular reviews and monitoring.

## References

Alzheimer's Society (2015)

*Dementia 2015: Aiming higher to transform lives*

NHS Digital (2018)

*Mental Capacity Act (2005) Deprivation of Liberty Safeguards England 2017-18 National Statistics*

House of Lords Select Committee on public service and demographic change (2013)

*Ready for Ageing?*