British Society of Rehabilitation Medicine

Promoting quality through education and standards

Position statement
Deprivation of Liberty in the Rehabilitation Setting

Definitions

The European Court of Human Rights ("the Strasbourg court") has confirmed that a deprivation of liberty for the purposes of article 5(1) has three elements:

1. the objective element of confinement in a restricted space for a non-negligible period of time;
2. the subjective element that the person has not validly consented to that onfinement; and
3. the detention being imputable to the state.

The "acid test" revealed in a line of cases in the Strasbourg court, involves determining whether the person concerned was:

a) under continuous supervision and control, and
b) not free to leave.

Both conditions must be satisfied in order to amount to a deprivation of liberty.

The Chief Coroner issued guidance (on 5 December 2014 which is not binding on coroners) concerning those who die when subject to a DoLS authorisation or a judicial authorisation of the deprivation of their liberty under the Mental Capacity Act. 'Whilst it is acknowledged that there are opposing views, the guidance advises that: on the law as it now stands, the death of a person subject to a DoLS should be the subject of a coroner investigation because that person was in state detention within the meaning of the Coroners' and Justice Act 2009'

The Law Commission have proposed a hospital scheme around the concept of deprivation of liberty. This is in part for practical reasons. Given all patients in hospital should be under supervision, the concept of a deprivation of liberty will focus on the "not free to leave" limb of the acid test. The law Commission have asked for views on this point.

The proposed hospital scheme would authorise deprivations of liberty in NHS and private hospitals where care and treatment is being provided for physical disorders, and in hospices. The hospital scheme would apply when the following conditions are met:

1. the hospital patient lacks capacity to consent to the proposed care or treatment as a result of an impairment of, or a disturbance in the functioning of, the mind or brain;
2. the patient requires, or there is a real risk they will in the next 28 days, require care or treatment in their best interests that amounts to a deprivation of liberty; and

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3. deprivation of liberty is the most proportionate response to the likelihood of the person suffering harm, and the likely seriousness of that harm.

The Law Commission also consider that the acid test may need to be elaborated in order to make it more relevant to hospitals. They suggest that when considering the "not free to leave" limb of the test, the focus will often need to be on what actions the staff would take if, for instance, family members or carers sought to remove them. In effect, the legislation could state that the person lacking capacity shall be considered to be deprived of liberty if:

1. they are not free to leave the hospital upon expressing a wish to do so or attempting to do so, or as a result of another person expressing a wish or attempting to remove them; and
2. they are subject to continuous supervision and control.

They propose provisionally that, where there is an immediate need for a deprivation of liberty, the person may be deprived of liberty for up to 28 days and they set out proposals for who should be responsible for assessing the patient and for managing and reporting DOLs.

Recognising that it may be necessary for someone to be deprived of liberty in a hospital for longer than 28 days, the law commission provisionally considers that a deprivation of liberty may only extend beyond 28 days if an Approved Mental Capacity Professional has also assessed the person and confirmed that the conditions are met, whereupon a deprivation of liberty is authorised for up to 12 months.

Pragmatic approach

The purpose of trying to define a pragmatic approach to DoLS is because the misapplication of DoLS not only takes up an excessive and inappropriate use of staff time thus drawing them away from key clinical priorities but, even more importantly, causes unacceptable distress to patients and families. For example, a patient with an inappropriately applied DoLS who dies, even when this is anticipated, is automatically referred to the coroner for investigation causing unnecessary distress to the family and delay in organising funerals.

Consideration also has to be given to whether a DoLS is in the patient's best interests. A DoLS can be unnecessarily restricted when a more patient-centred approach can achieve the same goal of maximising their liberty whilst maintaining their safety and well-being. For example, a DoLS would be disproportionately heavy handed for the patient who wishes to leave the ward for a coffee and requires accompanying to avoid getting lost within the hospital but will return voluntarily when prompted to do so.

By definition DoLS is applicable only in patients who lack capacity to make a decision to leave. If they have capacity, they can and should be allowed to leave, and it is the responsibility of the treating team to facilitate this safely, as far as is possible, even if this is deemed by the team to be an unwise decision.

The BSRM, therefore, proposes the following pragmatic approach. DoLS should be applied in a manner that is proportionate to the risk and clinical setting and should in part be determined by clinical judgement. When a patient is constrained by the fact of their physical disability, ie, they are immobile, their restriction of movement is not imputed by the state but by their condition. So, for example a patient in MCS or VS, or other profound disability should not be subject to a DoLS, simply because they cannot move around independently or require continuous supervision.

For more mobile patients, we also agree with the Law Commission's proposal that the judgement about whether a DoLS is applicable will depend on the anticipated response by NHS staff. If it is anticipated that were the patient to try to leave, this would engender calling of Security or Police to return the patient to the ward using an element of physical restraint, this situation may reasonably trigger a DoLS. If on the other hand a gentler persuasive approach by the ward staff is likely to be successful, this should not require a DoLS. So, for example, the following do not normally require a DoLS:

1. the patient who is independently mobile and may wish to leave the ward, but will accept advice to wait until suitable arrangements for their safety can be made; or
2. the patient who is independently mobile and may wish to leave the ward, but is likely to return with support and encouragement from a family member or member of staff; or
3. the patient who repeatedly expresses a desire to leave, but when offered support to leave chooses not to, or having visited another setting expresses a desire to return to the first.

With respect to the Law Commission's recommendations on process and administration, we highlight that in some rehabilitation settings patients who do require a DoLS may continue to require this throughout their stay, which may be up to a year or more. It needs to be acknowledged that assessing capacity in patients with cognitive and communication difficulties is very skilled and may need input from speech and language therapists and psychologists familiar with the patient. Approved mental capacity professionals need to be aware of the challenges in the assessment of these patients. It will thus be necessary to ensure that the requisite number of approved mental capacity assessors are readily available to cope with case load, and these assessors need to have skills in assessing people with language and cognitive deficits.

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