

DOLS 2008: Immersed and sinking?

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- Acute tertiary/quaternary hospital
- 560,000 outpatients under treatment per year
- 145,000 inpatients per year; (397 per day); 15 ITU/HDU facilities

- We admit patients only for treatment, providing no living arrangements
- Most are then rendered transiently incapax for 1-21 days
- Most are then discharged to where they live.

Inpatients usually lose their capacity in acute hospital

- Due to:
- Obtunded or confused due to their presenting illness, transiently.
- Medication, analgesia
- Fear, anxiety, pain, distress, disorientation
- Anaesthesia
- Intensive or high dependency care.

Situation prior to Wednesday 19th March 2014

- Prior to the judgement, we relied on DOLS (2.6) arrangements to identify and protect the rights of those patients whose restrictions for treatment amounted to deprivation of liberty. It was a clinical decision, enabled by either prior discussions with a patient before they lost capacity; or with those who befriended an incapacitated patient.
- Akin to the process of the *treatment* of those with incapacity.
- DOLS application rate 2-15 per month, 2011-2013

The effect of the acid test

- 25-40% (100-160) of our inpatients on any one day were deprived of their liberty on the basis of Lady Hale's acid test in *Cheshire West & Ors*
- Country-wide, alarm raised by local authorities and acute trusts (amongst others)
- Courts realised the difficulties that increased applications would cause.

Digesting Lady Hale's judgment (i)

- P1 first sentence; “This is a case about criteria for judging whether living arrangements.....amount to deprivation of liberty”
- P58 last sentence; “ ...I would make a declaration that their living arrangements...”

Digesting Lady Hale's judgment (ii)

- Discussion pp45-56; explicitly related to living arrangements or residence 45,46,47,48
- Application to P&Q pp52-56; explicitly related to living arrangements 52,53,54,56
- Acute (non-mental) hospitals not mentioned in judgement?
- Some parrots *reside* in gilded cages (p46); but their psittacosis is treated at the veterinary hospital

Digesting Lady Hale's judgment (iii)

- Residential care; Not (generally) staffed by clinicians experienced in complex decision-making
- Acute clinical ward UHS; Invariably staffed by doctors and nurses whose daily practice revolves, when treating incapacitated adults, around decisions made after consultation with accompanying persons
- *Tracey v Cambs [2014] & Aintree v James [2013]* engrained in staff.

Where next, post judgment?

- Flood of applications to LA certain
- Risk of staff 'losing focus' highly likely if 100-160 applications per day
- Risk of patients who were at real risk of liberty violation being 'lost' in flood (return time from LA soon reached 20 weeks)
- Residual uncertainty of Court's intention for the acid test to be applied to acute hospitals...not least to ITU/HDU areas

When acid test is engaged

- In residential care: Application as the next step is required, since no certainty of experienced decision makers
- In clinical care: The next step involves staff, in whom the process of detailed decision-making 'using' the accompanying persons akin to the MCA 2005 s4(7) is engrained.

If acid test *will* be engaged in UHS; interim plan (i)

- If a patient with capacity presents to hospital for treatment, and you know that the intervention will entail deprivation of liberty, incorporate the disclosure of the impending deprivation with disclosure to obtain their consent for the intervention as a whole.
- Providing they are willing to provide consent both to intervention and deprivation, no *automatic* application when they (subsequently) engage acid test (during period of index treatment)

Acid test engaged; UHS interim plan (ii)

- ...No need for *automatic* authorisation if the incapacitating mental disorder is due to a physical illness, the treatment of which will involve a deprivation of liberty, but a **rapid** resolution of the mental disorder is expected.....s6.3 DOLS CoP.
- Review this decision if clinical concern, or accompanying persons express anxiety, or if rapid resolution fails to transpire.

Acid test engaged; UHS interim plan (iii)

- Incapacitated patient befriended: Discussion between accompanying persons and clinicians to decide whether sufficient concerns exist to necessitate application. If all are content that if they had capacity, the patient would agree to deprivation, no application.
- Application if any hint of dissonance at any stage, from any source

Acid test engaged; UHS interim plan (iv)

- Automatic DOLS application when incapacitated patient is unaccompanied, and not falling within s6.3 DOLS Code of Practice

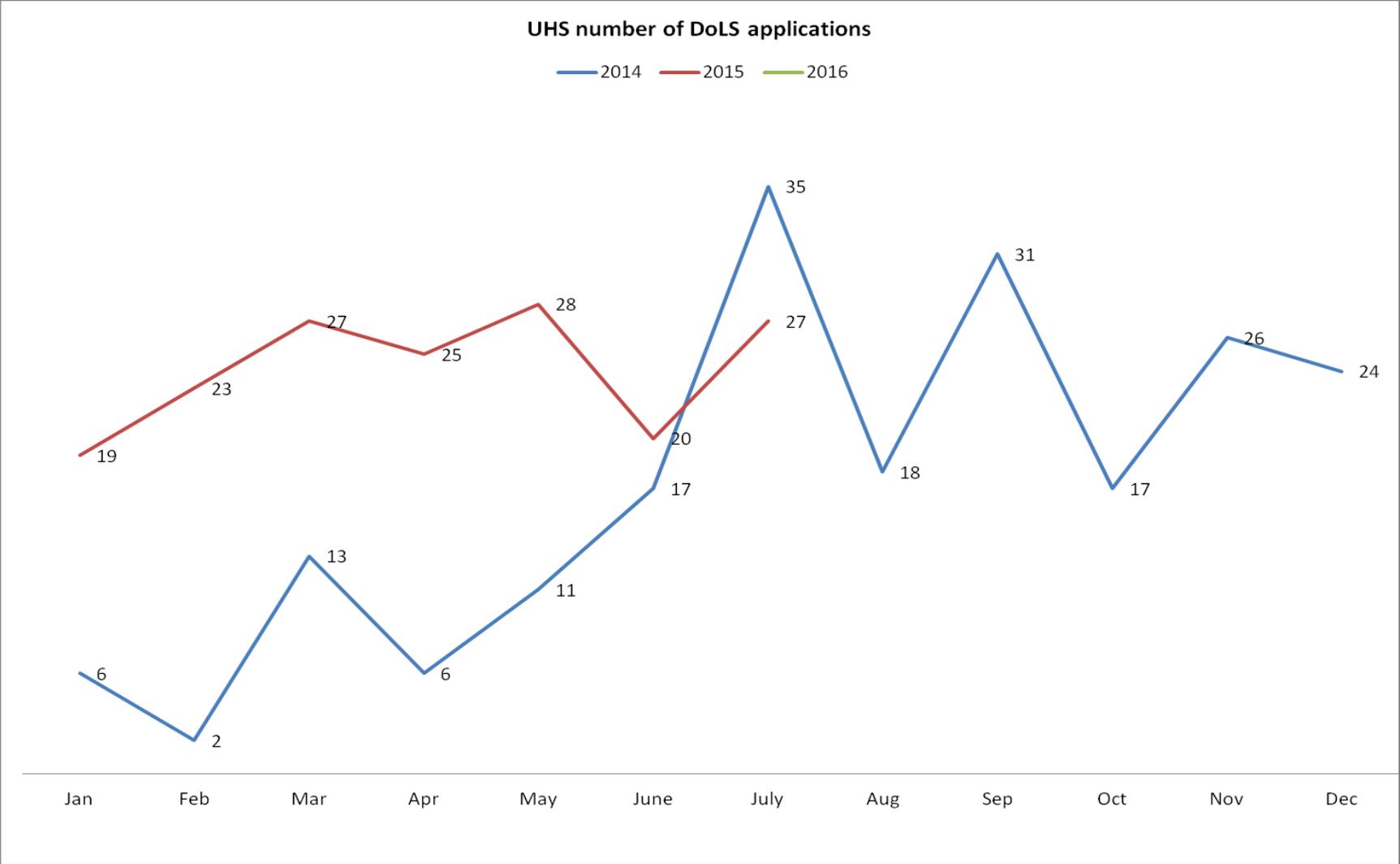


Illustration of model in acute hospitals?

- *NHSTs 1&2 v FG [2014] EWCOP Keehan J 30 28/8/14*
- On the facts, we would have automatically made a standard application during the process of planning FG's delivery.
- Clinical anxiety related to, amongst others, the position in which she was placed by her delusions would have made this inevitable, whether or not she was accompanied.
- Authority for her deprivation via s16(2)(a) MCA 2005 or inherent jurisdiction.

Results

- No challenges so far
- Average 24 applications per month
- High clinical awareness of the importance of patients' liberty
- LA response time below 6 weeks
- No patients who warranted application (but failed to have one made) identified

DOLS immersed?

- Plainly swamped
- But from the *clinicians'* viewpoint, properly resourced, DOLS still provides a mechanism for authorisations of deprivation that are activated by clinical or bystanders' concerns or dissonance; or if the patient is unbefriended.

Conclusion

- We are acutely aware of the onerous duty to protect the human rights of our patients
- We hope that the decision to make an application for deprivation of liberty will be established as a matter for clinical discretion, based on a legal standard.
- Thank you.