# Do BIA assessments under DoLS have a positive impact for people?

## Results of a national survey

September 2016

## Summary
A national online survey of DoLS BIA assessors asked them to identify the positive outcomes of their assessments as part of the DoLS process. Ninety-two BIAs completed the survey and provided a total 468 examples of positive outcomes. The results provide the most detailed evidence of the impact of BIA assessments since they began in 2009.

## Why
The survey was triggered by the publication of the Law Commission's interim statement on its proposals to replace DoLS. The statement contained the following quote:

*"Most consultees perceived the DoLS to be overly technical and legalistic and, more significantly, to have* ***failed to deliver improved outcomes for people*** *who lack capacity and their families and other unpaid carers."* (emphasis added)

*Law Commission, Mental Capacity and Deprivation of Liberty, Interim statement (25 May 2016)*

Having provided training for BIAs since 2009 I did not feel the above comment reflected what BIAs had told me. They reported finding significant numbers of people in inappropriate placements, or with inappropriate (too restrictive) care plans, which they challenged through their assessments. The study was therefore designed to provide an evidence base of the outcomes BIAs identified as a result of their assessments .

## Method
A brief online voluntary survey was made available for one month (17 June to 16 July 2016). Participants had to provide their name, email address and confirm they were a qualified BIA. The central survey question asked BIAs to identify one (or more) example of improvements to a person's care plan as a result of their assessment. The information provided was anonymised so that no names, dates or places were given.

## Response
Ninety-two BIAs completed the survey and provided a total 468 examples of positive outcomes for people and/or their family or carers resulting from their assessments. This is substantially more BIAs than responded to the Law Commission's four-month consultation on DoLS last year (49). No previous research has provided such detail in terms of the impact or outcomes resulting from BIA assessments.

## Findings
There were a total of 468 examples of the positive impact arising from the BIA assessment process. It is notable that over a third of respondents provided at least six different examples. It would have been easy for respondents to give just one example and finish the survey as this was a readily available option but BIAs had multiple examples to offer. Nearly 20% of respondents gave nine or ten different examples of improvements in care as a result of their assessments. The survey was limited it to a maximum of 10 examples for each participant and it appears likely that some respondents would have given more than ten if this had been an option.

From analysing the 468 examples it is possible to group them into a number of different themes which are given in the table overleaf:

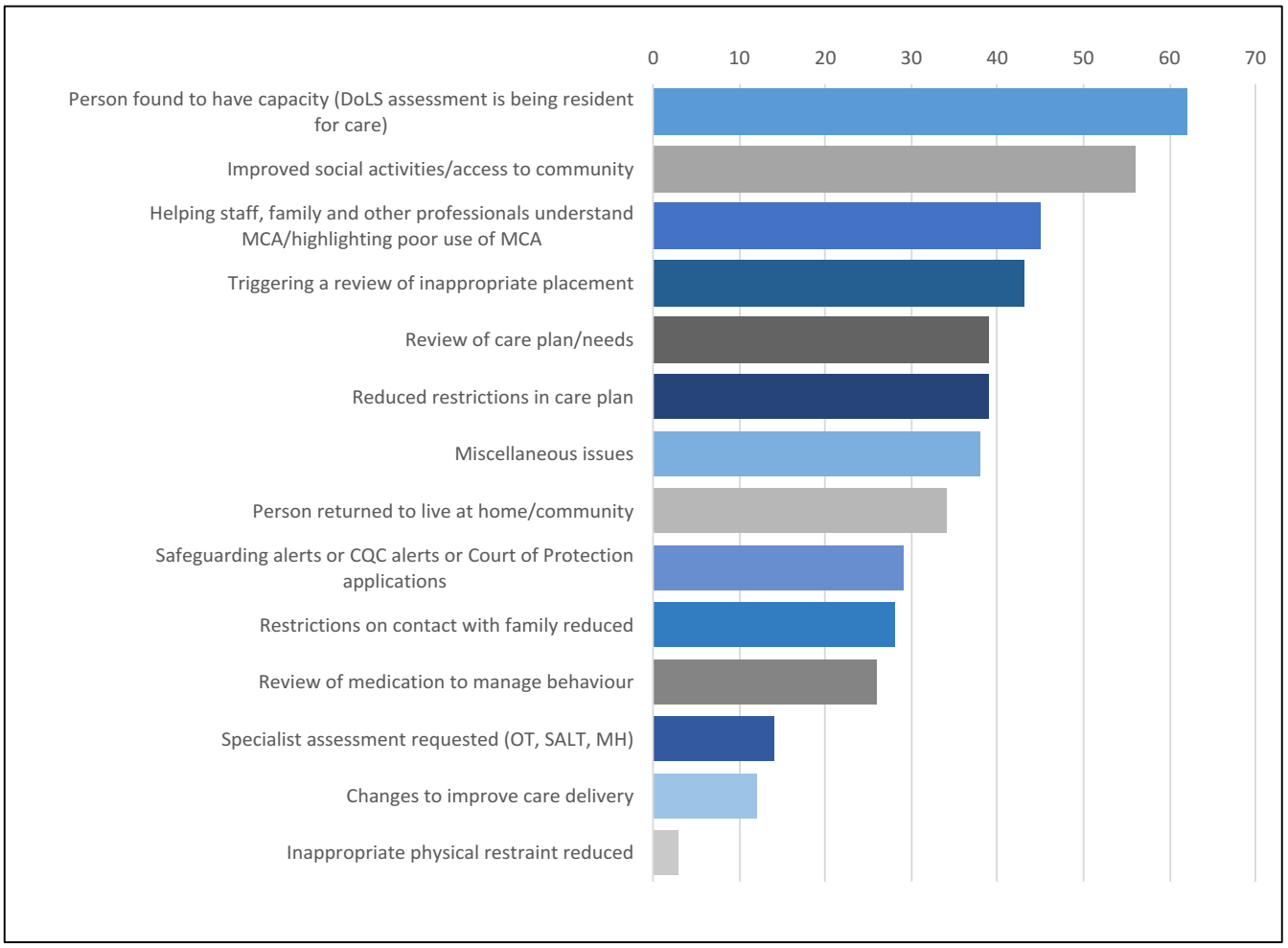
**Person found to have capacity:** The most regular and startling outcome of the BIA assessment (62 out of 468) was finding that a person who had been labelled and treated as lacking capacity (by the care provider) did in fact have capacity when properly assessed by an independent, specially trained professional. It is hard to understate the huge change (or *improved outcome* to use the language of the Law Commission) a person will experience from being found to have capacity. Examples given by BIAs included:

*"P had been assessed as lacking capacity when she was in fact making an unwise decision to live at risk in her own home. She was subsequently discharged."*

*"Finding a person has capacity and lifting all restrictions that the care home placed with no negative consequences for the person."*

*"individual where MCA hadn't been applied appropriately, he had capacity and wanted to go home so this was arranged"*

**Summary of BIA assessment outcomes**




**Person returned to live at home/community:** In many cases finding a person had capacity led directly to another outcome which was the person returning to live in their own home or the community rather than in a care home or hospital. In other cases, the outcome of the BIA assessment was for a person who lacked capacity to be returned to live in their own home in their best interests. Examples given by BIAs included:

*"Returning home! - It's hard for some to believe but a person that lacks capacity can live in their own home.."*

*"Influenced a move from a care home totally not suitable to the person, which was placing him at greater risk of harm."*

*"Supported P to return home to be with her husband rather than remain in placement funded by the CCG. She now has a live in carer to support her."*

**Improved social activities/access to the community:** The second most reported outcome (56 out of 468) was an improvement made to the person's social activities or access to the community following a BIA assessment. The activities highlighted by BIAs ranged from ensuring a person was able to access the community on a regular basis, enabling access to a piano, support to attend church on a monthly basis, visits by dogs or cats and access to an interpreter to speak to someone in their own language on a regular basis.

*"A condition was placed on the home to enable P to have reasonable access to the community. A recommendation was made to the service commissioners to scrutinise its contract with the service as the practice of not enabling P to go out was unreasonably restrictive. The care home began to escort the person out into the community on a regular basis to the person's great enjoyment, and in line with her wishes and previous habits.."*

**Helping staff, family and other professionals understand MCA/highlighting poor use of MCA:** Examples given by BIAs included:

*"The care home staff thought using a lap belt was a restraint and that restraint is not permitted. So P did not go out. I was able to show how restraint is defined and can be authorised by the MCA and the person was enabled to go out. Very often services do not know when and how to carry out an assessment of capacity and nor how it should be recorded. In my view being a proponent of the Act is a really important part of the BIA role."*

*"Often a DoLS assessment uncovers that appropriate financial arrangements are not in place leaving P vulnerable to abuse and unnecessary financial outlay."*

*"Family representative commented that the DoLS form 3 empowered him to negotiate care arrangements with the care home such that his elderly parent was enabled by staff to get up and walk at least six times a day rather than sitting in a chair all day."*

*"As a result of consultation with social workers and others, they have become acutely aware when their practice has fallen short ie no mental capacity assessment or best interests decision made or recorded prior to P being admitted to care home."*

**Care plans and placements:** Another key outcome were reviews of care plans or placements which were considered to be inappropriate when assessed by the BIA. Examples given by BIAs included:

*"Finding that a care home could not manage risks posed and therefore stipulating a review of placement."*

*"Many cases identifying the need for specialist in behavioural management. Without BIA involvement no action was identified or taken"*

*"Person had mental capacity but was sharing room with someone who had severe dementia. No-one to talk to. Needed change of room and more access to social environment."*

**Less restrictive care:** Not surprisingly, given that BIAs are bound by the MCA, they must consider less restrictive options (a central principle of the Act) as part of their assessment. This resulted in a substantial number of cases where the BIA challenged the restrictions placed upon people in their care plans.

*"Restraint was being used to deliver personal care to P on a daily basis. This caused agitation and distress. P was continent and I concluded that the level of restraint was not necessary or proportionate."*

*"Supporting a person to stop being kept in an "annex", which was just a room and allowed full access to a care home."*

*"One BIA assessment led to the immediate change of placement for a man with learning disabilities and autism where inappropriate and highly restrictive physical restraints were being used which could have put him in danger."*

A BIA reported challenging the care of a young man only allowed escorted leave outside and successfully changed it to unescorted: "*This leave has worked so well it has been increased and the social worker and care home report that this is the happiest and most stable this young man has been for years.."*

**Medication:** Another notable outcome was triggering reviews of medication most commonly connected to concerns about inappropriate use of antipsychotic medication to manage behaviour. This issue has been raised by NHS England in relation to people with a learning disability (14 July 2015. Publications gateway ref: 03689 www.england.nhs.uk/2015/07/14/urgent-pledge). It would appear that BIAs are providing an effective vehicle to challenge the use of such medication as part of considering less restrictive options in the DoLS procedure.

*"initiating meds reviews, particularly around polypharmacy, increased falls in elderly and use of psychotropic meds."*

*"Arranged urgent medication review for person over medicated."*

*"Arbitrary use of PRN sedatives at night reassessed as a result of the DOLS assessment process."*

**Contact with family:** Another area of concern identified by BIAs was restricted contact with family. The intervention of BIAs in this matter resulted in actions to reduce such restrictions and protect the Article 8 rights (private and family life) of individuals.

**Safeguarding and the Court of Protection:** Finally, BIA assessments led to a significant number of safeguarding referrals, CQC alerts and Court of Protection referrals.

*"Initiated institutional safeguarding investigation into care and treatment of service users on a dementia unit, including the culture of the institution."*

*"Person unlawfully deprived. Placed at care home for respite and left there. Application made to CofP as person had a sense that she had been duped."*

*"BIA was able to raise concerns and safeguarding. CQC put home requires improvement. BIA was in a strong position to influence change around poor practice."*

## Conclusion

The results of the survey provide substantial and clear evidence that BIA assessments both identify failings in care for vulnerable adults and more importantly result in real changes and improvements to care delivery in many different ways.

What emerges from reading the more than 460 individual examples is an alarming and depressing picture of poor care arrangements, overly restrictive practices, inappropriate use of medication to manage behaviour, disempowered families, residents labelled as lacking capacity (because they have dementia for example) without this ever being properly assessed and inappropriate placements. Where other assessments (care reviews for example) and other health or social care staff have failed to identify these very real and concrete problems, it is the BIA assessment – a direct independent legally based professional assessment – that does. The assessment also provides a means to change the situation and deliver improved outcomes for people. As one respondent noted*: "I feel extremely strongly that this safeguard has and continues to raise the standard of care for individuals who lack capacity."*

This confirms a statement by Alistair Burt, Minister of State for Community and Social Care in the House of Commons on 17 June 2015: *'Although some may baulk at the idea of 100,000 DOLS applications a year, we should remember that every one of those applications represents a person having their care independently scrutinised. DOLS can help to shine a light on care that is unnecessarily restrictive and does not put the person's views first and foremost. Therefore, we should strongly back the principles of DOLS.'*

For many of the people, assessed by the BIAs, the inappropriate care or restrictions were not new but had been in place for several years and would have continued if a BIA assessment had not taken place.

The findings of this study support and confirm previous, less detailed, research by the National Institute of Health Research in 2014. Their findings included:

- DoLS led to detailed scrutiny of care practice.
- Evidence that the DoLS procedure brought about beneficial changes in a person's care.

(National Institute for Health Research, School for Social Care Research, *The Deprivation of Liberty Safeguards: their impact on care practice (2014)* www.sscr.nihr.ac.uk)

## Discussion

DoLS has many different components and surely it is incumbent on those considering any new legislation, that will affect tens of thousands of vulnerable adults, to properly consider the evidence base of what works and what does not work in the current system before proposing changes to it.

In explaining the judgment of the Supreme Court in the Cheshire West case, Lady Hale stated: *'Because of the extreme vulnerability of people like P, MIG and MEG, I believe that we should err on the side of caution in deciding what constitutes a deprivation of liberty in their case. They need a* ***periodic independent check*** *on whether the arrangements made for them are in* ***their best interests****.'* (emphasis added).

The results of this survey provide clear evidence to support the importance of an independent professional face to face assessment bound by the requirements of best interests (section 4) of the Mental Capacity Act. While Lady Hale and others have commented that the DoLS procedure is too complex and could be simpler, it would appear from this study that the removal of the central protection of a direct independent professional assessment would deny the *'independent check'* which is so crucial to the care of vulnerable people.

The Law Commissions interim statement itself stated: *"..we do not accept that safeguards should be reduced to the bare minimum or that we should not consider any reforms that may generate additional costs. We remain committed to the introduction of a new scheme that delivers article 5 ECHR safeguards in a meaningful way for the relevant person and their family. Moreover, there are some reforms that remain fundamental to our new scheme and will need to be properly financed, such as rights to advocacy."*

What appears not to be working effectively in many cases are existing care assessments and reviews for people in care homes or hospitals. The 400+ examples given in the survey appear to be for many for people who had had care assessments and reviews of care already but these had failed to identify and address concerns that BIAs subsequently found during their assessment. Why? Because they do not have the legal rigour or focus of a BIA assessment, they can be undertaken by unqualified staff and may not even involve the person having a face to face assessment as under DoLS for the BIA assessment. A serious concern therefore is that one of key proposals to replace DoLS is to rely on these assessments instead.

The legislation to replace DoLS is still at a very early stage and will undoubtedly undergo many changes from drafting to being submitted and then debated by Parliament. BIAs need to consider how they can come together to effectively influence the legalisation so that proper account is taken of the significance of an independent professional, face-to-face and MCA based assessment in protecting the rights of vulnerable adults.

**Thanks**
I would like to thank all the BIAs who took the time to complete the survey and for the detailed examples they gave. A full copy of the survey results is available upon request from the email address below.

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**Limitations**
The survey was undertaken by Steven Richards, director of Edge Training and Consultancy Ltd. Edge provides training to BIAs and so could be seen to have a financial interest in maintaining the role of the BIA in the future. However, BIA training is not central to the company as we deliver a wide range of MHA and MCA training to many different organisations across the country.

The survey only asked respondents to provide positive examples of the impact of BIA assessments so excluded the possibility of people giving negative responses. It was not the intention of this study to provide a complete picture of the DoLS procedure but just to look at one element. I would advocate that further research be carried out to build a stronger picture of the impact of BIA assessments and other elements of the DoLS process to provide an adequate evidence base for future legislation.

BIAs could be seen as financially motivated to give examples to prove their value. However, BIAs are professionals (social workers, nurses, occupational therapists and psychologists) and the 468 examples they provided clearly demonstrate the impact of their assessments on the individuals and their family or carers.