Mandatory Training Workbook 2015

Mental Capacity Act and Deprivation of Liberty Safeguards

Clinical & Medical Staff

Checklist

- ***Read through this section of the workbook.***
- ***Complete the on-line assessment on*** My PACT
- ***If further information is required please contact the Joanne Shaw on 1857***

Mental Capacity Act

The Mental Capacity Act 2005, covering England and Wales, provides a statutory framework for people who lack capacity to make decisions for themselves, or who have capacity and want to make preparations for a time when they may lack capacity in the future. It sets out who can take decisions, in which situations, and how they should go about this. The Act received Royal Assent on 7 April 2005 and will come into force during 2007.

The legal framework provided by the Mental Capacity Act 2005 is supported by a Code of Practice (the Code), which provides guidance and information about how the Act works in practice. The Code has statutory force, which means that certain categories of people have a legal duty to have regard to it when working with or caring for adults who may lack capacity to make decisions for themselves.

http://nww.staffintranet.lhch.nhs.uk/Library/Corporate/DOLS/Mental%20Capacity%20Act%20Code%20of%20Practice.pdf

Mental Capacity Act Code of Practice

Certain categories of people are legally required to 'have regard to' relevant guidance in the Code of Practice. That means they must be aware of the Code of Practice when acting or making decisions on behalf of someone who lacks capacity to make a decision for themselves, and they should be able to explain how they have had regard to the Code when acting or making decisions.

The categories of people that are required to have regard to the Code include anyone who is acting in a professional capacity, this may include:

• a variety of healthcare staff (doctors, dentists, nurses, health care assistants, therapists, radiologists etc)
• social care staff (social workers, care managers, etc)
• others who may occasionally be involved in the care of people who lack capacity to make the decision in question, such as ambulance crew for a Primary PCI.

However, the Act applies more generally to everyone who looks after, or cares for, someone who lacks capacity to make particular decisions for themselves.

What does 'lacks capacity' mean?

One of the most important terms is 'a person who lacks capacity'. Whenever the term 'a person who lacks capacity' is used, it means a person who lacks capacity to make a particular decision or take a particular action for themselves at the time the decision or action needs to be taken. This reflects the fact that people may lack capacity to make some decisions for themselves, but will have capacity to make other decisions. For example, they may have capacity to make small decisions about everyday issues such as what to wear or what to eat, but lack capacity to make more complex decisions about financial matters. It also reflects the fact that a person who lacks capacity to make a decision for themselves at a certain time may be able to make that decision at a later date. This may be because they have an illness or condition that means their capacity changes such as Post Operative Delirium. Alternatively, it may be because at the time the decision needs to be made, they are unconscious or barely conscious whether due to being under anaesthetic or their ability to make a decision may be affected by the influence of alcohol or drugs.

Finally, it reflects the fact that while some people may always lack capacity to make some types of decisions – for example, due to a condition or severe learning disability that has affected them from birth – others may learn new skills that enable them to gain capacity and make decisions for themselves.

Mental Capacity – does this affect patients here?

The first question is does the person have a disturbance or impairment of the functioning of brain? For example : dementia, delirium, stroke, brain injury, cognitive impairment or learning difficulties.

If the answer is yes then it does not mean that the person lacks capacity, you must always presume a person has capacity.

The second question is does the disturbance affect the persons decision making ? Can they retain, weigh up and communicate a decision through any means: ie blinking , squeezing of a hand or if possibly verbally. If they are unable to meet any of these criteria we must consider the deprivation of Liberty safeguards

Deprivation of Liberty Safeguards

The Deprivation of Liberty Safeguards (DoLS) came into force on 1st April 2009. They were Introduced into the Mental Capacity Act by the Mental Health Act 2007. DoLS were introduced to close the Bournewood gap. In the Bournewood Case, (HL v the United Kingdom (2004) 45088/99), the European Convention of Human Rights (ECHR) concluded that there was a gap in the law (which became known as "the Bournewood Gap"). Essentially, there were no formal Legal Safeguards for the rights of vulnerable people, who lacked capacity to consent to institutional care, and whose care might amount to a deprivation of their liberty.

There was also no method by which these individuals could seek speedy access to court, to challenge the circumstances of their care, and the potential breach of their human rights. It was hoped that the introduction of DoLS would close the Bournewood Gap.

Who does it apply to?

Adults over 18; and

- Are (or will be) in a hospital or care home; and
- Are suffering from a mental disorder (under S1 of the MHA 1983 (Any disorder or disability of the mind - e.g. dementia, alzheimers, learning difficulties including downs syndrome and autism, brain injury, schizophrenia)); and

- Lack the mental capacity to give consent to the arrangements made for their care or treatment; and
- for whom such care may potentially amount to a deprivation of their liberty, but it is regarded as necessary and in their best interests to protect them from harm.

Factors that may indicate a Deprivation of Liberty:

- Use of restraint, including sedation
- Staff have complete control over care and movement for significant periods
- Staff control visitors/residence and treatment
- Refusal of a carers request to discharge a patient
- Patient unable to maintain social contact
- Loss of autonomy due to continuous supervision and control
- The person objecting to admission or remaining in a hospital or care home or to the care and treatment provided there.

Each individuals case must be assessed on its own facts and circumstances. The existence of one of the above factors may indicate a deprivation of liberty or a combination of some of those factors. It is important to look at the nature, duration and intensity of any restrictions on the patients liberty, in order to decide whether, on the facts of that particular case, the patient may be being deprived of their liberty.

Deprivation of Liberty Safeguards Framework - Summary

(Managing Authority - Treating Hospital or Care Home, Supervisory Body - The Patients Local Authority)

Where a hospital or care home identifies that a person who lacks capacity and meets the DoLS criteria is at risk of being deprived of their liberty, the managing authority must make a written request for 'authorisation' of the deprivation of liberty from the supervisory body.

The managing authority is the body responsible for the running of the hospital. It is therefore essential that the hospital managers understand how to identify a potential deprivation of liberty and have robust poilicies to ensure

compliance with the DoLS procedures, in accordance with the appropriate timescales.

The supervisory body must then carry out a series of assessments to determine whether authorisation should be granted.

If the person is over 18 and is in hospital in England or Wales then an application must be made to the Local Authority from where the patient resides. For International, scottish, Irish or Isle of Man Patients, where they do not reside in England or Wales, applications must be made to the Hospitals Local Authority. If a patient is under 18, an application must be made direct to the Court of Protection and not the relevant local authority as above.

Authorisation must, wherever possible, be sought in advance of admission, i.e. before the deprivation of liberty has begun. An urgent authorisation can be sought in an emergency for 7 days (sometimes exceptionally extended by the superviosry body for a further 7 days).

When a supervisory body receives a request for authorisation of a deprivation of liberty, it must obtain 6 assessments before making a decision:

- Age Assessment
- No refusals assessment
- Mental Capacity Assessment
- Mental Health Assessment
- Eligibility Assessment
- Best Interests Assessment

The general rule is assessments must be completed within 21 days of the supervisory body receiving the request for authorisation.

If an urgent authorisation has been given, assessments must be completed before the expiry of the urgent authorisation, i.e. within 7 days.

If authorisation is granted, it will be lawful to deprive the person of their liberty, subject to ongoing review. If authorisation is granted with conditions, the managing authority must ensure those conditions are met. If authorisation is not granted, it will be unlawful to admit the patient and further care planning will be needed. If the patient is admitted without authorisation, legal claims for unlawful detention are likely to follow.

What is the issue with the Deprivation of Liberty Safeguards and what has changed?

Previously there has been a lack of clarity on what constitutes a deprivation of liberty which means, there has also been a lack of clarity about when a manahging authority, i.e. hospital or care setting, must request authorisation from a supervisory body to deprive a patient of their liberty. In March 2014, the cases of P v Cheshire West and Chester County Council and P&Q (MIG & MEG) v Surrey County Council were heard before the supreme court.

The Supreme Court allowed the appeals of both cases and ruled that P, MIG and MEG had been deprived of their liberty. In the Cheshire West Case, it did so unanimously. In the P&Q case, it did so by a majority vote of four to three.

In her leading judgement, Lady Heale rejected the Court of Appeals approach in Cheshire West for determining whether or not someone was being deprived of their liberty. She stated that since disabled people enjoy the same rights as everyone else, what constitutes a deprivation of liberty for an able bodied person is also a deprivation for a disabled person. As such, it is not relevant that a mentally disabled persons surroundings are 'relatively' normal; that he or she does not object to the placement; or that the arrangements are an appropriate means of achieveing the best outcome for the person. These factors may justify a deprivation of liberty - but they do not determine whether there has been a deprivation in the first place. Instead Lady Hale stated that the test for identifying a deprivation of liberty is whether the person is under continuous supervision and control and are not free to leave.

The objective nature of Lady Hales test means that even the most benevolent arrangements now amount to a deprivation where there is continuous supervision and control, and where the person is not free to leave. It is irrelevant whether or not the person objects to the arrangements or has tried to leave. The quality of care or treatment is not relevant to this question, for, as Lady Hale put it, 'a gilded cage is still a cage'.

Supreme Court Definition of a Deprivation of Liberty (Acid Test)

There is a Deprivation of Liberty where:

- The person is under continuous supervision and control; and is not free to leave; and the person lacks capacity to consent to these arrangements.

Factors irrelevant to whether there is a deprivation:

- The persons compliance or lack of objection;
- the relative normality of the persons placement;
- the appropriateness of the arrangements for achieving the best outcome for the person.
- The question is, if all of the above applied and the person tried to leave, what would you do?

As a consequence of the supreme court ruling, there is now a wider definition and as a result supervisory bodies are likely to see an increase in authorisation requests from managing authorities. It will also see an increase in the number of applications being made to the Court of Protection for authorisation where the person is being deprived of their liberty is in a supported living arrangement (which does not fall under the DoLS regime).

Jargon Buster

- “P”- the person
- Capacity to make a decision – refers to a specific decision that needs to be made (see box below). Decisions for people who lack capacity must always be made in a person’s best interests.
- Independent Mental Capacity Advocate (IMCA) There is already a statutory requirement to an IMCA where a person has no friends or family to represent them when a change of accommodation or when serious medical treatment is being considered. This use of the IMCA will be extended to provide support to people who have no friends or family during the best interests assessment. They may also be used to provide advice and when a family member is acting as a representative.

- Bournewood case or judgment - a landmark ruling that resulted in the need for deprivation of liberty legislation.
- Cheshire West – The Local Authority responsible for commissioning “P’s” care and the organisation authorising the deprivation of liberty.
- Managing Authority – the setting where a deprivation or proposed deprivation of liberty occurs; a hospital or care home.
- Section 12 doctor – a specially trained doctor who will confirm a person’s diagnosis and make recommendations to the best interests assessor.
- The best interests assessor – a specially trained person who undertakes an assessment to see if a deprivation of liberty is occurring, and if so, whether a deprivation of liberty order is required.
- Deprivation of liberty authorisation – granted by a supervisory body for a period of up to one year.
- Supervisory body – the panel who will authorise the deprivation of liberty order on the recommendation of the best interests assessor. Either a local authority or Primary Care Trust (could be a joint panel).
- Representatives - a person being assessed or on a deprivation of liberty order will have a representative. They will be an appropriate family member or a paid professional.