SET Mental Capacity Act and Deprivation of Liberty Safeguards Policy and Guidance

Southend Safeguarding Adults Board
Essex Safeguarding Adults Board
Thurrock Safeguarding Adults Board

(Version 2 - March 2018)

Document Control Sheet

Title:	Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) Policy & Guidelines.
Purpose:	To provide the framework for assessing people's mental capacity, as well as assessing best interests in line with the Mental Capacity Act 2005 including Deprivation of Liberty Safeguards 2009 and Codes of Practice.
Type:	Policy & Guidelines
Target Audience:	All those involved in assessment, planning, support, care management or review of adults receiving care and support services within Southend, Essex and Thurrock.
Date approved: **Review Date:**	March 2018 March 2019
This replaces:	Mental Capacity Act Guidelines and Deprivation of Liberty Safeguards Policy & Guidelines.
This should be read alongside:	This document is compliant with all relevant legislation at the time of publication and adheres to the current SET Safeguarding Adults Guidelines and SET Safeguarding and Child Protection Procedures.
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Introduction

This Southend, Essex and Thurrock Policy & Guidelines document has been devised to provide guidance on both the Mental Capacity Act 2005 MCA and the Deprivation of Liberty Safeguards 2009 (DoLS). This document therefore has two main sections to separate out the different categories of use and then a third part including helpful references and appendices, in particular the locally adopted forms to record mental capacity assessments, best interests decisions and to make an IMCA referral. The forms have been adopted to support evidencing best practice.

It is important to note that the Mental Capacity Act and Deprivation of Liberty Safeguards (MCA & DoLS) Guidelines do not replace the Mental Capacity Act 2005, nor the Deprivation of Liberty Safeguards Amendment or the respective Codes of Practice. However it aims to provide guidance that interpret and link the information to local best practice.

You can download the Mental Capacity Act Code here:

http://www.publicguardian.gov.uk/docs/mca-code-practice-0509.pdf

The Deprivation of Liberty Safeguards Supplement Code is available here:

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_087309.pdf

Practitioners must always have regard to the Codes of Practice and evidence their decision making in line with it. If they have not followed the guidance contained in the Codes, they will be expected to give good and valid reasons on why they have departed from it (CoP, p 1-2).

The full Codes of Practice of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (2009) can be found here[1].

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/224660/Mental_Mental capacity_Act_code_of_practice.pdf

PART 1 – THE MENTAL CAPACITY ACT 2005

1. The Mental Capacity Act 2005

The Mental Capacity Act 2005 provides the legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make specific decisions. Everyone working with or caring for an adult who may lack mental capacity must comply with the Mental Capacity Act 2005 and the Code of Practice (2007).

1.1. Principles of the Mental Capacity Act 2005

The Mental Capacity Act 2005 applies to individuals aged 16 and over and sets out five statutory principles as below:

1. A person, must be assumed to have mental capacity unless it is established that he/she lacks mental capacity s.1(2);
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him/her to do so have been taken without success S.1(3);
3. A person is not to be treated as unable to make a decision merely because he/she makes an unwise decision S.1(3);
4. An act done, or decision made, under this Act for or on behalf of a person who lacks mental capacity must be done, or made, in his/her best interests S.1(5);
5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action S.1(6).

This means:
Every person (aged 16 and over) capable of making decisions, has an absolute right to accept or refuse care, treatment or other intervention regardless of the wisdom or consequences of the decision. The decision does not have to be justified to anyone. Without valid consent or without a mental capacity assessment and subsequent best interest decision, any invasion of the body, however well-meaning or therapeutic, will be a criminal assault.
There is specific guidance that concerns decisions made in emergency situations and in relation to protection from legal liability in latter sections of this document.

1.2 Where there is an issue about mental capacity

Where there are doubts about an individual's mental capacity to consent to an action that concerns them, a formal assessment of their mental capacity to make this specific decision must be carried out in line with the five statutory principles, and the

Guidance of the MCA 2005 Code of Practice and the following sections of the Mental Capacity Act 2005[2].

- A person must be assumed to have mental capacity unless it is established that he/she lacks mental capacity S.1(2).
- A person lacks mental capacity in relation to a matter, if at the material time, he/she is unable to make a decision for him/herself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain S.2(1).
- The question of whether a person lacks mental capacity must be decided on the balance of probabilities S.2(4).
- A person is not to be treated as unable to make a decision unless all practicable steps to help him/her to do so have been taken without success S.1(3).
- A person is not to be treated as unable to make a decision merely because he/she makes an unwise decision S.1(4).
- Where a person is unable to make a decision for him/herself, there is an obligation to act in his/her best interests S.1(5).
- Where a decision relates to life-sustaining treatment, the person making the decision must not be motivated by a desire to bring about death S.4(5).
- When determining what is in a person's best interests, consideration must be given to all relevant circumstances, to the person's past and present wishes and feelings, to the beliefs and values that would be likely to influence his/her decision if he/she had mental capacity, and to the other factors that he/she would be likely to consider if he/she were able to do so S.4(6).
- The presumption that the adult has mental capacity is fundamental to the Act. It is important to remember that the adult has to 'prove' nothing. The burden of proving a lack of mental capacity to take a specific decision (or decisions) always lies upon the person who considers that it may be necessary to take a decision on their behalf (or will invite a court to take such a decision). The standard of proof, which must be achieved, is on the balance of probabilities S.2(4). Accordingly, it will always be for the decision-maker to prove that it is more likely than not that the adult lacks mental capacity.

It is our policy to comply with the Mental Capacity Act, its Code of Practice and any other relevant national guidance, and leading judgements when making decisions about a person's mental capacity or deprivation of liberty.

1.3 Decisions not covered by the Mental Capacity Act and therefore outside the scope of this Guidelines

Mental Capacity Act (2005) (s.27) excludes;

[2] References are taken from the Mental Capacity Act and not the Code of Practice

- consenting to marriage or a civil partnership
- consenting to have sexual relations
- consenting to a decree of divorce on the basis of two years' separation
- consenting to the dissolution of a civil partnership
- consenting to a child being placed for adoption or the making of an adoption order
- discharging parental responsibility for a child in matters not relating to the child's property, or
- giving consent under the Human Fertilisation and Embryology Act 1990.

1.4 Assessing Mental Capacity

There is no requirement to assess mental capacity unless there are doubts about the individual's mental capacity to make a specific decision at the time it needs to be made. Part 3 of this document refers to a locally adopted mental capacity assessment form, which can be used for recording such an assessment.

1.4.1 The diagnostic component of the test for mental capacity

The diagnostic component of the test is broad and by itself cannot lead to the conclusion that someone lacks mental capacity to make a decision. It is the 'effects' of some of the conditions that can cause impairment/disturbance such as confusion, disorientation, and drowsiness. Examples may include:

- Conditions associated with some forms of mental illness
- Dementia
- Significant learning disabilities
- Long-term effects of brain damage
- Physical or medical conditions that cause confusion, drowsiness or loss of consciousness
- Delirium
- Concussion following a head injury, and
- Symptoms of alcohol or drug use.

This requires that the individual has an impairment or disturbance of the mind or brain, whether temporary or permanent. This does not require that there is a formal diagnosis, rather that the decision maker believes, on the balance of probabilities and based on information available at the time, from records, information from others or the actual interview with the person, that the individual has an impairment or disturbance of the mind or brain. For a person to lack mental capacity to make a decision, the Mental Capacity Act 2005 says their impairment or disturbance must affect their ability to make the specific decision when they need to. Fundamentally, the person must first be given all practical and appropriate support to help them make the decision for themselves (see chapter 2, principle 2). The diagnostic

component of the mental capacity test/assessment can only apply if all practical and appropriate support to help the person make the decision has failed.

If the person does NOT have an impairment or disturbance of the mind or brain whether temporary or permanent, the person does **not** lack mental capacity within the meaning of the Mental Capacity Act. The assessors should **not** proceed to assess mental capacity via the functional/second stage.

However, individuals may struggle to make certain decisions at certain times because of a number of factors unrelated to any impairment or disturbance that they may or may not suffer. These factors will be:

- Pressure, coercion, duress (http://www.legislation.gov.uk/ukpga/2015/9/contents/enacted)
- Lack of sufficient information
- Information in an inaccessible format.

In this situation, assessors should ensure adjustments and support are offered to ensure that person is enabled to make their own decision. Practitioners are urged to familiarise themselves with the Serious Crime Act 2015 and need to adhere to this.

1.4.2 The functional components of the test for mental capacity

Can the individual:

1. *understand* the information relevant to the specific decision,
2. *retain* the information,
3. *weigh up the pros and cons* against their own values and morals and finally
4. *communicate* their decision (communication is a functional skill and via any means; speech, use of sign language, interpreters, writing).

The burden of proof is on the assessor to provide evidence that the person does not meet any of the four functional components of the tests and to prove that the person lacks mental capacity, if this is the case. This is because all persons aged 16 and over are presumed to have mental capacity, unless there is a concern that necessitates a mental capacity assessment.

1.4.3 The Causative Nexus

The question the assessor - needs to consider is whether there is a causative link between the impairment in the functioning of the brain or mind AND whether the person is unable to make the decision because of this impairment of their mind or brain.

If there is a causative link, the assessment can conclude that the person lacks mental capacity within the meaning of the Mental Capacity Act 2005 (as a result of the impairment).

If there is no link between the person having an impairment of the brain or mind and a link between impairment and 'inability' (to make a decision) then this decision may be an unwise decision, or a decision that is made as a result of duress, pressure or coercion. The mental capacity assessor needs to provide evidence in terms of reaching whatever conclusion.

1.5 Situational incapacity

Lack of mental capacity as a result of an impairment/disturbance in mind/brain must be distinguished from a situation where a person is unable **to make their own decision as a result of duress or undue influence**. A person who has the mental capacity to make decisions may have their ability to give free and true consent impaired if they are under constraint, coercion or undue influence. Duress and undue influence may be affected by eroded confidence due to fear of reprisal or abandonment, sense of obligation, cultural factors, power relationships or coercive control within domestic abuse. If you have a concern that the person may be under duress/coercion or undue influence in relation to the making of this decision, this will not satisfy the Stage 1 (Diagnostic) test. Practitioners should support individuals to be able to make decisions freely by creating a supportive and conducive environment. In complex situations, practitioners should consult their managers and seek legal advice, which may lead to proceedings in the Court of Protection or the High Court under its inherent jurisdictions.

> Example: *Jack (82) has complex physical needs and vascular dementia. He is living in a residential care home and the district nurse is visiting next week to provide the residents with a flu vaccination. The care home manager has asked the senior carers to complete mental capacity assessments on residents where there is 'reasonable doubts' about mental capacity to consent to their flu vaccinations.*
> *Amy (one of the carers in the home) meets with Jack to tell him the district nurse wishes to give him a flu vaccination next week and she wishes to check whether he understands. Jack explains he understands perfectly but he does not want a flu vaccination, 82 is a good age and he does not want to live much longer, if he gets the flu and dies that is fine, it would be better than living with dementia and just becoming less able.*
> *Amy concludes that Jack does understand the information relevant to the decision (about having a flu vaccination) and that there is no requirement to undertake an assessment of his mental capacity to evidence this and that he is refusing his flu vaccination. Amy then records the conversation in the clinical notes and advises the care home manager and district nurse of Jack's decision.*

1.6 Day-to-day decisions

Where paid carers are undertaking the day-to-day care of an individual, they are reminded that an individual needs to validly consent to that care. Where an adult has not validly consented to that care, then carers could potentially face a charge of

criminal assault. In practice, many individuals, such as those living with dementia or a severe learning disability, may lack the mental capacity to make a decision about a significant number of decisions involving their day-to-day care, such as consenting to assistance with showering or with eating and drinking. In such circumstances, it would get in the way of the provision of care and support if the carer were to have to seek to gain consent and assess mental capacity, on every single occasion that assistance was required.

Assessments of mental capacity regarding day-to-day decisions should be carefully recorded. This does not need to be documented on the Southend, Essex and Thurrock MCA Assessment Form but could be documented in the individual's care plan, risk management plan or case notes. It must include the actual mental capacity assessment (if the individual is unable to validly consent), and separately, best interests decisions, or actions. This must be relevant to the specific care, support or treatment decision in question. The Southend, Essex and Thurrock locally adopted MCA Assessment Form can be used and is designed to support you through the process and ensure that the assessment complies with legislation and best practice. You should also ensure you follow your organisational guidelines, policy and procedures. Providers of care are expected to record such assessments, which they will need to produce in any inspection, such as by the Care Quality Commission, to evidence their compliance with the Act.

1.7 Complex decisions

A complex decision may be one where there are serious or long-term consequences for the adult, such as:

- a change of accommodation
- limitations on who they can have contact with
- medical treatment which will have long term consequences or may endanger life
- major financial decisions that may involve for example mortgages
- entering into or terminating tenancy agreements
- consent to sexual relations (specific legal test applies, refer to current case law).

This list is not exclusive, but in all these circumstances, assessments MUST be undertaken by an appropriately qualified and competent professional with appropriate support from specialist colleagues such as speech and language therapy, psychology, safeguarding or following legal advice. In cases of doubt about who should appropriately assess, advice should be sought from your agency lead for Mental Capacity Act and/or senior managers as appropriate.

Complex decisions should be recorded on the MCA Assessment Form. This replaces the previously used forms known by acronyms; MCA1 and MCA2.

Where staff members are working across different local authorities outside of Southend, Essex and Thurrock, they should ensure that the mental capacity assessment and subsequent decisions, or indeed best interests decisions where someone lacks mental capacity; are clearly documented. This need not be on the Southend, Essex and Thurrock MCA Assessment Form.

1.8 Determining mental capacity to consent where an individual refuses to engage in the assessment

There are occasions when adults may refuse to engage in an assessment of their mental capacity to make a specific decision. All efforts should be made to establish a rapport with the person to seek their engagement, and to explain the consequences of not making the relevant decision (MCA code of practice para 4.57-4.59). Where this occurs, professionals should advise the individual that, if they decline to engage, the professional will need to make a determination of the individual's ability to make this specific decision on the balance of probabilities, taking into account the knowledge they already have about the individual their cognitive abilities, diagnosis and presentation.

Where an individual refuses to engage because they do not understand (due to their impairment or disturbance of the mind or brain whether temporary or permanent), then the decision maker can conclude, on the balance of probabilities, that the individual lacks mental capacity to agree or refuse the assessment and the assessment can normally go ahead, although no one can be forced to undergo an assessment of mental capacity.

Example: *Mavis has severe learning and physical disabilities and is living in a residential care home. Her carers have called her GP to examine her, as they are concerned that she is physically unwell. Her GP wishes to take her blood to check if she is anaemic. The GP seeks Mavis's consent to take her bloods but Mavis is non-verbal. The GP together with a carer from the care home, with whom Mavis has a positive relationship, attempt to explain to Mavis through signing and use of a talking mat (communication aids that Mavis is familiar with), however, Mavis is becoming agitated and distressed. The GP (who is the decision-maker) concludes, on the balance of probabilities, that:*

- *as Mavis appears unable to comprehend the information being provided to her,*
- *she has a known diagnosis of severe learning disabilities,*
- *she appears to be physically unwell and*
- *her carers advise that it is unlikely she would have mental capacity to consent to this decision,*

on the balance of probabilities, she lacks mental capacity to consent to the blood test. Taking bloods is necessary to ensure Mavis does not have a serious underlying physical condition - consequently the GP prescribes some diazepam/ valium (a chemical sedative) and uses a topical anaesthetic cream (such as EMLA) to ensure that the blood test can proceed. The diazepam is essentially the lawful use of restraint (under s5 MCA) and is in Mavis's best interests to enable the blood tests to be completed in the least distressing manner.

1.9 Reviewing mental capacity assessments

It is important to review mental capacity from time to time, as people can improve their decision-making capabilities. In particular, someone with an ongoing condition may become able to make some, if not all, decisions. Some people will learn new skills throughout their life, improving their mental capacity to make certain decisions. Therefore, assessments should be reviewed from time to time. Mental capacity should always be reviewed:

- whenever a care plan is being developed or reviewed
- at other relevant stages of the care planning process, and
- as particular decisions need to be made.

This will ensure that there is a lawful basis for ongoing provision of care/support and/or treatment. Carers must recognise that an individual may have mental capacity in respect of some day-to-day decisions, such as choice of clothing, but not others and that mental capacity can fluctuate over time.

If the person's condition does not change and the original mental capacity assessment recorded on the form remains valid and applicable to the same decision, the care plan should reflect this.

1.10 Making a decision in an individual's Best Interests

Best interests is not defined in the Act, but a section sets out a checklist (often referred to as the 'best interests checklist') of factors which must be considered in determining an individual's best interests, before a decision can be made or an action taken on their behalf.

Inevitably, the 'best interest's checklist' cannot cover every eventuality, so other factors should be taken into account depending on the individual circumstances. In summary factors that will be relevant in all situations are:

- Equal consideration and non-discrimination
- Considering all relevant circumstances
- Whether the person may regain mental capacity, as if possible the decision may need to be delayed till then
- Permitting and encouraging the person to participate
- Special consideration should be made for life-sustaining treatment
- The person's wishes and feelings, beliefs and values must be considered
- The views of other people such as their friends and family must be considered before any decision is made.

These include the requirement that an individual should take into account the views of 'anyone named by the person as someone to be consulted on the matter in question' or 'anyone engaged in caring for the person or interested in his welfare'. The principle of equal consideration reminds decision-makers that they must not make assumptions about what a person's best interests might be simply on the basis of their age, appearance, condition or behaviour and that every effort must be taken not to act in a discriminatory way. Where possible the person's values should be explored to understand how they may have made a decision themselves if they were able to. This could include considering previous decisions they made when they had mental capacity, if this applies to them.

Fair application of the standard of best interests requires that professionals consider the medical, social, psychological and emotional benefits of a decision and that they fully explore with the individual, the pros and cons of any proposed decision, providing full information of all potential risks and any reasonable alternatives, before determining decisions in best interests. Decision makers must record their professional reasoning of this **balance sheet approach** and how their reached the conclusion.

More information about the balance sheet approach of weighing up the pros and cons can be seen in case law such as *Aintree University NHS Hospitals Trust vs James 2013 UKSC 67.*

1.11 Who can assess mental capacity?

The Mental Capacity Act 2005 is very clear that the individual who is going to take action or make a decision on behalf of an adult should be the person who assesses their mental capacity. They do not need to be a 'qualified' individual but should have the necessary skills and knowledge of the Mental Capacity Act and Code of Practice. The decision maker or assessor has to 'satisfy themselves' that the relevant person lacks mental capacity in the matter to be decided if they intend to make a best interests decision. There are however, limited instances where it is permissible for the assessor and decision maker to be two different individuals, for example, the assessor may be the professional, the decision maker, the registered LPA or deputy in the matter. Examples include:

Decision to be made	**Assessor**
Adult needs to have dental treatment	Dentist
Adult needs to be admitted to a hospital bed	Ward manager, charge nurse, staff nurse or medic on the ward, community staff to evidence lack of mental capacity and make best interests decision if applicable to send to hospital. Where the adult may be resisting being sent to hospital, community staff should evidence lack of mental capacity and best interest decision to send to hospital
Adult needs to have a blood test at the GP practice	The doctor who has requested the blood test will need to provide the information to the patient as to why the blood test is being conducted and (where necessary) assess mental capacity to consent to the blood test being conducted
Adult needs to have a care review	Person carrying out the review
Adult needs to have her incontinence pads changed	Person who is going to change her pads
Adult needs assistance eating	Person who is providing that assistance
Adult needs washing or dressing	Person who is providing that assistance
Adult needs to have a change of accommodation funded by social care	Social Work Professional
Adult living independently wishes to have social contact with friends and family who are subject of a safeguarding concern	Professional leading the safeguarding enquiry
Adult needs urgent medical treatment and is unconscious	Medical professional provides treatment without attempting to assess mental capacity, in best interests (para 6.35 MCA Code of Practice)
Adult wishes to enter into a sexual relationship	If there are doubts about person's ability to validly consent to sexual contact, mental capacity assessment should be undertaken by the most appropriate professional. However, if person lacks mental capacity, a best interests decision cannot be made on their behalf. Safeguarding procedures will apply and legal advice needs to be sought as required.

1.12 How many assessors are needed?

There is **no** requirement for a mental capacity assessment to be undertaken by more than one professional. In most cases, this will not be required or appropriate. However, it may be necessary in the following situations:

- Where significant restraint is required
- Where there is a known conflict about the care and support of the individual
- Where it is likely that the adult's family may dispute or complain about the outcome of the mental capacity assessment
- Where mental capacity is fluctuating or is difficult to assess
- Where a known co-dependent relationship is involved which has been a source of conflict or risk.

The Southend, Essex and Thurrock locally adopted assessment form enables recording of agreement or disagreement between the two assessors. One of the assessors will have the lead role and act as a decision maker. However, if there is a disagreement, further advice should be sought to resolve the situation and facilitate best outcome for the individual.

Examples:
A second assessor may be appropriate where specialist input into the mental capacity assessment is likely to result in a better outcome for the adult. An example of this would be the involvement of a behavioural specialist when an assessment involves an individual with a history of challenging or erratic behaviour. Consideration should always be given as to whether the presence of a second assessor may be overwhelming for the adult. If so, alternative arrangements for obtaining the specialist input should be explored.

Example: *Mohammed (43) was in a road traffic accident and has an acquired brain injury. He is currently in hospital. It has been previously determined that he lacked mental capacity to consent to admission and further mental capacity assessments have concluded that he lacks mental capacity to consent to treatment. Mohammed's mental capacity fluctuates as he begins to make progress following the road traffic accident and he is now ready for discharge. An assessment has determined that he requires a track hoist to be installed in his own home and it is unsafe for him to be discharged without this. Mohammed owns the house and his consent is required to install the track hoist.*

An Occupational Therapist (OT) has discussed the installation of the hoist with Mohammed but is concerned that he does not appear to understand what the hoist is for, and becomes very agitated every time the issue is raised. The OT has attempted to undertake a mental capacity assessment, but has found that Mohammed's speech is very difficult to understand as a result of the injury and his agitation makes this worse. Having met with Mohammed on two previous occasions the OT has concluded that they need the support of a professional colleague - a speech and language therapist who specialises in working with people with acquired brain injuries – to ensure that the assessment of mental capacity is fair and robust.

Having discussed the case in supervision the OT arranges a further appointment to undertake the assessment with her colleague present. They meet with Mohammed in a quiet room on the ward and bring with them some pictures of a track hoist to help them explain to Mohammed what decision they are seeking his consent to. It is clear that Mohammed does wish to go home from hospital but he appears unable to comprehend that he will need a track hoist. They document the outcome of their assessment.

Following the assessment, they conclude that Mohammed does not, on the balance of probabilities, have mental capacity to consent to the installation of a track hoist. They therefore consult with both his sister and professionals involved in his care and note his expressed wishes about getting home soon and that his sister also believes that he would prefer to be at home rather than in hospital. They conclude that the installation of a track hoist would be in his best interests, as it will enable his earlier discharge back home.

1.13 When can a family member or friend be present at the assessment of mental capacity?

All practical steps must be taken to support an individual to make a decision. This may include facilitating and supporting family members to share their views with the individual before the formal assessment of mental capacity commences but only if the person agrees.

Family members or friends have no automatic right to be present when an assessment of mental capacity is being undertaken. Family members can be present in assessments only where there will be no negative impact on the process of assessment, and if the presence of a family member will appropriately support the individual to make his/ her own decision.

Decision makers must be aware that the presence of a family member during the assessment could result in a challenge that the outcome of the assessment is invalid especially if the individual whose mental capacity is being assessed has been coerced, or has made a decision under duress, coercive control or undue influence.

Where a family member is present, they should be advised that they must not prompt the individual whose mental capacity is being assessed or lead their family member during the assessment and the decision maker/assessor has clearly documented that the presence of the family member is a practical step which will support the individual to make a decision.

Where it is determined that an individual lacks mental capacity and the decision maker is consulting with others, then 'remember that the person who lacks mental capacity to make a decision or act for themselves still has the right to keep their affairs private so it would not be right to share every piece of information with everyone' (MCA Code of Practice, pg. 66).

1.14 Disputes regarding the outcome of assessments of mental capacity

Where there is a dispute or disagreement about the outcome of an assessment of mental capacity – for example, where a professional has concluded an individual does have mental capacity to decide where they wish to live and a family member is determined that the person whom the assessment concerns lacks mental capacity to make this decision, then professionals are reminded that it is the decision-maker who has the final determination regarding the outcome of the assessment.

Professionals should take into account the concerns of family or friends if they dispute the outcome of an assessment and where necessary they can request a second opinion on that assessment. Where a dispute is anticipated prior to the assessment occurring, consideration should be made to use two professionals who can jointly assess an individual's mental capacity to make a specific decision.

Where, having involved a second professional, there is disagreement between them about the outcome, for example one concludes on the balance of probabilities that the individual has mental capacity, whilst the other concludes on the balance of probabilities that they do not have mental capacity; then the decision maker needs to consider the risks of concluding the outcome of the decision. Specialist assessments of mental capacity can be commissioned from independent assessors in exceptional circumstances. Also, the ultimate arbiter in resolving disputes in relation to assessments of mental capacity or best interests is the Court of Protection. Legal advice or advice from senior managers and/or the lead for MCA and/or safeguarding should be sought in these situations as appropriate

1.15 Restraint (also see 2.19 – Deprivation of Liberty Safeguards**)**

The right to liberty is a universal right guaranteed by the European Convention on Human Rights to everyone. If restraint is necessary in the best interests of the individual, then any restraint used must be a proportionate response to the degree of harm that might otherwise occur. The nature of the restraint used, length of time it lasted and reasons why it was used must be clearly documented.

The Act allows restrictions and restraint to be used in a person's support, but only if this is in the best interests of the person who lacks mental capacity to make the decision themselves. Restrictions and restraint must be proportionate to the harm the caregiver is seeking to prevent, and can include:

- using locks or key pads which stop a person going out or into different areas of a building
- the use of some medication, for example, to calm a person
- close supervision in the home, or the use of isolation
- requiring a person to be supervised when out
- restricting contact with friends, family and acquaintances, including if they could cause the person harm
- physically stopping a person from doing something which could cause them and/or others harm
- removing items from a person which could cause them and/or others harm
- holding a person so that they can be given care, support or treatment
- bedrails, wheelchair straps, restraints in a vehicle, and splints
- the person having to stay somewhere against their wishes or the wishes of a family member
- saying to a person they will be restrained if they persist in a certain behaviour.

Section 6(4) of the Mental Capacity Act states that 'someone is using restraint if they:

- use force – or threaten to use force – to make someone do something that they are resisting, or
- restrict a person's freedom of movement, whether they are resisting or not.' (Section 10.4) MCA Code of Practice.

In an emergency: if a person who lacks mental capacity to consent has challenging behaviour, or is in the acute stages of illness causing them to act in a way which may cause harm to others, staff may, under the common law, take appropriate and necessary action to restrain or remove the person, in order to prevent harm, both to the person concerned and to anyone else (Section 6.43 - MCA Code of Practice).

Wherever possible, carers should seek to minimise the use of restraint. The Social Care Institute for Excellence (SCIE) provides a range of literature designed to provide guidance to carers to minimise the use of restraint in specific settings.

1.16 Covert Medication

Covert medication involves administering medicines in disguised form, for example in food and drink, where a person is refusing treatment necessary for their physical or mental health. Covert medication must never be given to someone who is capable of consenting to medical treatment. If the person's decision is thought to be unwise or eccentric, it does not necessarily mean they lack mental capacity to consent.

Administration of medication against a person's wish may be unlawful. Adults who have been assessed as lacking mental capacity to consent to be given specific medication can only be administered medicine covertly if a management plan is agreed after a best interests' assessment. The decision maker will be the healthcare professional prescribing the medication

Once a decision has been made to covertly administer a particular medicine (following an assessment of the mental capacity to consent to be given medicine and a best interests decision concluded) there needs to be a plan as to how, the medicine can be covertly administered. Such a plan should include whether it is safe to do so and to ensure that need for continued covert administration is regularly reviewed, especially as mental capacity can fluctuate over time. Medicines should not be administered covertly until a best interests decision has been made.

Where a best interests' decision has been made to administer medicine covertly, advice should be sought from a pharmacist, for example to be clear about the effect of crushing the medication. Crushing medicines and mixing with food or drink to make it more palatable or easier to swallow when the service user **has consented to this**, does **not** constitute covert administration. The National Institute for Clinical Excellence (NICE) and organisations such as the Nursing and Midwifery Council (NMC) and the General Medical Council (GMC) have produced guidelines on medication management in care homes, which should be followed.

1.17 Assessments of mental capacity for individuals who have a donee of Lasting Power of Attorney (LPA) or a Court Appointed Deputy

If a friend or relative states that they are a donee of LPA or deputy, personal welfare and/or property and affairs, then the decision maker must assure themselves of the validity of such statements by requesting to see a copy of the relevant registrations or court order/s. An LPA or Deputy for Property and Affairs cannot make a decision relating to Health and Welfare. Equally, an LPA or Deputy for Property and Affairs cannot make decisions relating to the person's Health and Welfare when they lack mental capacity to do so. It is only when the person has dual LPA or Deputyship that decisions can be made regarding both Health and Welfare and Property and Affairs.

Where it is concluded that an individual lacks mental capacity to make a decision *and* they have a donee of LPA or Deputy then, unless there are safeguarding

concerns about the LPA or deputy, the decision maker is the donee of LPA or the Deputy.

If you are concerned that donee of the LPA or the Deputy is not acting in the best interests of the individual, then you must raise an urgent safeguarding concern (SET Safeguarding Adult Guidelines) and discuss the matter with your line manager urgently as legal action may be required. The Office of the Public Guardian will also need to be notified.

Where the decision maker is a health or social care professional, they have a duty to consult the person appointed as a donee or deputy. The decision maker remains the health and social care professional as they have the legal liability.

Any member of staff asked to sign as a Certificate Provider for the purposes of the establishment of an LPA or Deputyship must seek advice from their manager, as some organisations expressly prohibit their staff from acting in this capacity.

1.18 Advance statement

Caring for people at the end of their lives is an important role for many health and social care professionals. One of the aspects of this role is to discuss with individuals their preferences regarding the type of care they would wish to receive and where they wish to be cared for in case they lose mental capacity or are unable to express a preference in the future. These discussions clearly need to be handled with sensitivity and skill. The outcomes of such discussions may then need to be documented, regularly reviewed and communicated to other relevant people, subject to the individual's agreement. This is the process of Advance Care Planning (ACP) and known as an advance statement.

For individuals with no concern about lack of mental capacity, it is their current wishes about their care, which need to be considered. Under the MCA 2005, individuals can continue to anticipate future decision making about their care or treatment should they lack mental capacity. In this context, the outcome of ACP may be the completion of a statement of wishes and preferences or if referring to refusal of specific treatment may lead onto an advance decision to refuse treatment (Chapter 9 MCA 2005 Code of Practice). This is not mandatory or automatic and will depend on the person's wishes. Alternatively, an individual may decide to appoint a person to represent them by choosing a person (an 'attorney') to take decisions on their behalf if they subsequently lose mental capacity (Chapter 5 MCA 2005 Code of Practice).

A statement of wishes and preferences is not legally binding. However, it does have legal standing and must be taken into account when making a judgement in a person's best interests. Careful account needs to be taken of the relevance of

statements of wishes and preferences when making best interests decisions (Chapter 5 MCA 2005 Code of Practice).

1.19 Advance decisions to refuse treatment

If an advance decision to refuse treatment has been made it is a legally binding document if that advance decision can be shown to be valid and applicable to the current circumstances. In all cases, an individual's contemporaneous mental capacity must be assessed on a decision-by-decision basis if there are doubts about mental capacity. An individual may retain the ability to make a simple decision, but not more complex decisions (Chapter 4 MCA 2005 Code of Practice).

It is essential that where an advance decision is made, a copy of this is held in the individual's clinical records and that the individual is encouraged to share copies with family and those health and social care professionals coordinating their care.

An advance decision must be followed where it is concluded that an individual lacks mental capacity to make a specific decision about their medical treatment and it is known that they have previously made a valid and applicable advance decision, relating to the proposed specific medical treatment. If it is a refusal of life sustaining treatment then it must contain a statement that the advance decision applies even if their life is at risk. These decisions should be signed and witnessed. Decision makers are advised to consult senior clinicians as required.

An advance decision can only be overruled if it relates to treatment of a mental disorder and the individual has been detained under the Mental Health Act (1983). If the individual has made a specific decision to refuse ECT, the guidance in s59-62 of the Mental Health Act, (1983) and the MHA Code of Practice must be followed.

Those working with and caring for individuals with life limiting conditions may find the guidance at NHS Choices, www.ncpc.org.uk or www.compassionindying.org.uk helpful.

There is no legal template for recording advance decisions to refuse treatment and advance directives. However, Compassion in Dying provides a useful template for recording both advance directives and advance decisions. It is recommended that providers of care use these forms to record advance decisions to refuse treatment and advance directives.

1.20 Continuing Health Care (CHC) funding

Everyone aged 16 and over, is presumed to have mental capacity regardless of their presentation, disability or behaviour (s.1(2) MCA, 2005). Consequently, it is not a requirement that all those referred for consideration of Continuing Health Care funding require an assessment of their mental capacity to consent to the referral to

the panel. Mental capacity is presumed and assessments of mental capacity to consent to specific decisions should only occur where doubts are raised about an individual's mental capacity to validly consent to the referral or engage in the assessment process.

> Example*: Julia is an 88 year old with advanced dementia, has multiple physical health problems and has recently developed acute vascular disease as a result of her poorly controlled diabetes. She is living at home with support from the Local Authority however, she needs more clinical support than she is currently getting. The community matron working with her social worker believes that Julia meets the criteria for Continuing Health Care.*
> *The case is referred to the clinical commissioning group for a decision on funding, and in view of Julia's complex clinical presentation, they refer it to the continuing healthcare (CHC) panel. The CHC panel are concerned that no mental capacity assessment has been undertaken and refuse to consider the case until this has been done. The community matron and social worker both advise that she is aware of and was able to validly consent to the referral to the CHC panel and was able to participate meaningfully in the continuing healthcare assessment process. Consequently there are no grounds for the panel to refuse to consider their application on Julia's behalf and the community matron and social worker remind the panel that the role of the panel is not to second guess the clinical recommendations (in line with the National Framework for Continuing Healthcare (DoH 2012).*

The National Framework for Continuing Healthcare (DoH, 2012) states that Assessments of eligibility for NHS continuing healthcare and NHS-funded nursing care should be organised so that the individual being assessed and their representative understand the process, and receive advice and information that will maximise their ability to participate in informed decision-making about their future care. Decisions and rationales that relate to eligibility should be transparent from the outset for individuals, carers, family and staff alike.

As with any examination or treatment, the individual's consent should be obtained before the start of the process to determine eligibility for NHS continuing healthcare. It should be made explicit to the individual whether their consent is being sought for a specific aspect of the eligibility consideration process, e.g. completion of the checklist, or for the full process, and for personal information to be shared between different organisations involved in their care. It should also be noted that individuals may withdraw their consent at any time in the process.

If an individual does not consent to assessment of eligibility for NHS continuing healthcare, the potential effect this will have on the ability of the NHS and the Local Authority to provide appropriate services should be carefully explained to them. The fact that an individual declines to be considered for NHS continuing healthcare does not, in itself, mean that an LA has an additional responsibility to meet their needs, over and above the responsibility it would have had if consent had been given. Where there are concerns that an individual may have significant ongoing needs,

and that the level of appropriate support could be affected by their decision not to give consent, the appropriate way forward should be considered jointly by the CCG and the LA, taking account of each organisation's legal powers and duties. It may be appropriate for the organisations involved to seek legal advice.

It is important to be aware that just because an individual may have difficulty in expressing their views or understanding some information, this does not in itself mean that they lack mental capacity. Appropriate support and adjustments should be made available to the person, in compliance with the Mental Capacity Act 2005, the Care Act and with the Equality Act 2010 to avoid discrimination of any kind.

If the person lacks the mental capacity to either give or refuse consent to the use of the Checklist, a Best Interests Decision should be complete and take the individual's previously expressed views into account. This should be taken and recorded as to whether or not to proceed with assessment of eligibility for NHS continuing healthcare. The person leading the assessment is responsible for making this decision and should bear in mind the expectation that everyone who is potentially eligible for NHS continuing healthcare should have the opportunity to be considered for eligibility. A third party cannot give or refuse consent for an assessment of eligibility for NHS continuing healthcare on behalf of a person who lacks mental capacity, unless they have a valid and applicable Lasting Power of Attorney for Welfare or they have been appointed a Welfare Deputy by the Court of Protection.

Where a Best Interests Decision needs to be made, the decision-maker must consult with any relevant third party who has a genuine interest in the person's welfare. This will normally include family and friends. However, third parties should not receive information where the patient has previously made it clear that they do not consent to information being shared with them.

1.21 Young people and the Mental Capacity Act

The Mental Capacity Act 2005 states that everyone aged 16 and over is presumed to have mental capacity. The Children Act 1989 notes that a young person does not legally become an adult until their 18th birthday. Section 8 of the Family Law Reform Act 1969 provides that young people age 16 and 17 have the right to consent to treatment and that such treatment can be given without the need to obtain the consent of a person with parental responsibility.

Where a young person aged 16 and over has mental capacity and does not consent to a decision, their wishes and views must be upheld. Professionals are advised against relying on the consent of a person with parental responsibility and are advised to seek legal advice if required.

Where a young person aged 16 and over lacks mental capacity to make a specific decision, the decision should be taken within the framework of the Mental Capacity Act 2005.

> Example: Sarah is 16 and suffers from a psychotic illness. The illness is preventing her from making decisions about her care and treatment. She is assessed to lack mental capacity within the meaning of the MCA 2005. Accordingly, decisions are made for her on her behalf within the legal framework of the MCA 2005. Whilst her parents are consulted and their views are taken into account regarding decisions about her care and treatment, final responsibility lies with the decision maker – the Responsible Clinician who has determined that Sarah should be prescribed and given medication.

> Example: Jack is 17 and attends A&E where he has disclosed to clinicians that he has been assaulted by a family friend. He also shares this information with Police. He states to both clinicians and the Police that he does not wish any information or detail about the assault to be shared with his parents, advising that he is concerned they will be distressed and that his father will wish to challenge his assailant. Whilst professionals are concerned that Jack needs his parents' support, they respect his right to confidentiality and record that there is no reason to doubt that Jack has mental capacity to make this decision in their records. Jack's parents are demanding that A&E clinicians tell them what exactly has occurred and clinicians advise that they do not have Jack's consent or agreement to share this information and that Jack has a legal right to make these decisions.

Clinicians are reminded that young people under the age of 16 may still have mental capacity or be Gillick-competent to make a decision (see here for information about Gillick-competence). For a young person under the age of 16, the professional has a duty to evidence that the young person has mental capacity or is Gillick-competent. The law presumes that a young person aged 16 and over has mental capacity to make all decisions.

1.22 Do Not Attempt Resuscitation

An assessment of mental capacity for important decisions such as a Do Not Attempt Resuscitation (DNAR) form should be completed when a DNAR is set in place for a person who lacks mental capacity. In the case of *Elaine Winspear vs City Hospitals Sunderland NHS Foundation Trust* the High Court has ruled that carers for patients without mental capacity should be consulted before a DNAR order is placed on the patient's medical records. Lack of consultation may trigger concerns about the right to life under Human Rights being breached.

Imposing a DNA CPR order is a sensitive and important decision, and now the Courts have made it very clear that it is not a decision for doctors to take alone. Clinical judgment plays a pivotal role in the decision making process, however a

patient's views and wishes, whether voiced by them directly or by another on their behalf, must be obtained.

1.23 Safeguarding adults at risk of abuse who lack mental capacity

1.23.1 Reporting concerns of abuse

If abuse of a person who lacks mental capacity is suspected or witnessed the SET adult safeguarding procedure must be followed. The links for the SET adult safeguarding procedure can be found in Part 3 of this document.

A mental capacity assessment should be conducted to check the views and wishes of the adult/adults that are allegedly being abused or wilfully neglected in relation to specific decisions taken as part of the process, for example to share information with the police (unless wider public interest applies), or to progress the enquiry. Every effort should be made to get full participation from the adult/adults concerned and they may require some support from an advocate or where they lack mental capacity they need to be given the support of an Independent Mental Capacity Advocate during the safeguarding process.

1.23.2 Section 44: Ill-treatment and neglect

An offence of ill-treatment or wilful neglect of a person who lacks capacity is set out in the Act. Ill-treatment and neglect are not defined in the Act but the following definitions have been agreed locally:

Ill-treatment is where, through the use of intimidation, bullying, coercion, physical or sexual harm, the carer treats a person who lacks capacity unfairly and with no regard for their civil liberties or human rights.

Neglect is the failure of the carer to provide appropriate care to a person who lacks capacity. This may include ignoring the person's medical or physical care needs, failing to get healthcare or social care and withholding medication, food or heating.

If you are concerned that Section 44 of the Mental Capacity Act applies, you need to contact the police for advice.

1.24 Independent Mental Capacity Advocates (IMCA)

Where the decision maker concludes the individual lacks mental capacity and the threshold for requesting an IMCA has been reached, then there is a statutory duty to provide an IMCA (Mental Capacity Act 2005).

An Independent Mental Capacity Advocate **MUST** be appointed where it is determined that an adult lacks mental capacity and has nobody to support them, other than paid staff, and a specific decision is being made about:

- A change of accommodation;

- A move to a care home for more than 8 weeks or an admission to a hospital bed for 28 days or more;
- Serious medical treatment;
- A Deprivation of Liberty Safeguard has been applied for the person to help keep them safe (See PART 2 for more information).

An IMCA **MUST** be instructed to support someone who lacks mental capacity to make decisions concerning:

- Care Reviews – where no-one else is available to be consulted
- Adult Safeguarding cases – whether or not family, friends or others are involved.

Although you may involve an IMCA under the Mental Capacity Act legislation, if there is no appropriate person, for people over age 18, you MUST instruct a Care Act Advocate if the person has substantial difficulty engaging with the relevant assessment & support planning/review/safeguarding process. Please use the most appropriate legislation to ensure entitlement to advocacy.

An IMCA is not a decision maker. They have the right to be consulted but they do not make the decision. Further guidance on the role of the IMCA can be found in the MCA Code of Practice and IMCA guidance.

PART 2 – THE DEPRIVATION OF LIBERTY SAFEGUARDS (DOLS)

2.1 Introduction to the Deprivation of Liberty Safeguards (DoLS)

The distinction between a deprivation of, and restriction upon liberty, is merely one of degree or intensity and not one of nature or substance.

Deprivations of Liberty Safeguards do not apply to adults who are lawfully imprisoned or are lawfully detained under the provisions of the Mental Health Act.

A person may not be deprived of their liberty **without lawful authority.** To do so may render the authority liable for civil or criminal penalties and those providing care and/or treatment in such circumstances will not be protected from legal liability.

The whole point about human rights is their universal character. The European Convention on Human Rights (ECHR) sets out a series of articles that guarantee rights to "everyone" (article 1). They are premised on the inherent dignity of all human beings whatever their frailty or flaws. The provisions of the ECHR are binding on the states that are signatories to the convention. The United Kingdom is a signatory to the ECHR and the rights within it have been incorporated into domestic law in the Human Rights Act 1998.

The ECHR Article 5(1) states that: "*Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law*' and Art 5(1)(e) provides for the lawful detention of persons of unsound mind. ECHR Article 5(4) - ensures that "*Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful.*"

In England and Wales, you can only be lawfully deprived of your liberty if you are under arrest, if you are sentenced to detention by a court, for example if sent to prison, or detained under the provisions of the Mental Health Act 1983, or detained under a Court order, or, DoLS authorisation in the case of the Mental Capacity Act 2005, Deprivation of Liberty Safeguards, 2007. Each is a procedure prescribed by law and each provides a means of appeal or 'speedy access to a court' to enable the grounds for detention to be lawfully reviewed.

2.2 When can deprivation of liberty be authorised?

It is common ground that for a deprivation of liberty authorisation to be granted under DoLS, three components must be met. These are derived from European case law and require that there is an objective component of confinement in a particular restricted place for a not negligible length of time; a subjective component that the

individual is unable to validly consent to the arrangements for their care and/or treatment and lastly that the arrangements are attributable to the state.

Case law:
The key piece of case law is Cheshire West and Chester Council v P [2014] UKSC 19. In this case, Hale LJ observed that:
'*it is axiomatic that people with disabilities, both mental and physical, have the same human rights as the rest of the human race'…* and noted that '*Those rights include the right to physical liberty, which is guaranteed by article 5 of the European Convention. This is not a right to do or to go where one pleases. It is a more focussed right, not to be deprived of that physical liberty. But, as it seems to me, what it means to be deprived of liberty must be the same for everyone, whether or not they have physical or mental disabilities. If it would be a deprivation of my liberty to be obliged to live in a particular place, subject to constant monitoring and control, only allowed out with close supervision, and unable to move away without permission even if such an opportunity became available, then it must also be a deprivation of the liberty of a disabled person. The fact that my living arrangements are comfortable, and indeed make my life as enjoyable as it could possibly be, should make no difference. A gilded cage is still a cage'* (Cheshire West, paras 45-46).

2.3 The Acid Test – What a deprivation of liberty looks like

The Deprivation of Liberty Safeguards apply to an individual aged 18 and over who is being cared for in a registered care home or hospital bed (regardless of how this is funded – i.e. whether state or private). The Acid Test is a list of conditions identified in the Cheshire West case which, when satisfied, will identify whether or not a person is being deprived of their liberty. A person will be deprived of their liberty when he or she:

- is being deprived of their liberty for more than a few days,- the law does not define this concept in terms of days, but does state this is for a "not negligible length of time" (Storck v Germany (2005) 43 EHRR 6, para 74; Stanev v Bulgaria (2012) 55 EHRR 696,paras 117 and 120). You must use your professional judgement and ensure all actions are recorded with the clinical reasoning to support them being in evidence. In any event, if it is anticipated the deprivation will last 7 days or more an application MUST be made. (Please refer to DoLS Code of Practice para: 6.3 and 6.4).
- is subject to continuous supervision and control (i.e. in practice there is a care plan, which requires that carers know their whereabouts at all times) AND as Acid test requires all 3 components to be present.
- is not free to leave (i.e. in practice the individual is unable to leave without the support of a carer or family member and would not be permitted to live elsewhere unless the provider and commissioner of the care agreed to a change of accommodation).

- under the responsibility of the state for any aspect of the supervision of their care, however that care is funded or provided. For example, every care provider registered with the CQC, support living arrangements brokered by the local authority.

However it is important to note that for the acid test to be met the individual in question has to also lack capacity to consent to the care arrangement that is causing the deprivation.

A young person under the age of 18 can also require authorisation of a Deprivation of Liberty from the appropriate Court.

2.4 Key responsibilities of care homes and hospitals in their role as Managing Authorities

- To adapt care-planning processes to ensure consideration is given to whether a person lacks mental capacity to consent, in accordance with the Mental Capacity Act 2005, to the services which are to be provided and whether their actions are likely to result in a Deprivation of Liberty.
- To consider before admitting a person to a hospital or residential care home in circumstances that may amount to Deprivation of Liberty, whether the person's needs could be met in a less restrictive way. To ensure that any restrictions are the minimum necessary and in place for the shortest possible period.
- To take steps to help the relevant person retain contact with family, friends & carers.
- Where local advocacy services are available, their involvement should be encouraged to support the person & their family, friends & carers.
- To ensure clear and robust procedures are in place for staff to offer guidance and clarity on when a request for a standard authorisation would be required, and the procedures that should be followed in order to make an application to the Supervisory Body. This requires clear procedures, policy and guidance relating to the use of restraint and restrictive practices.
- No one should be deprived of their liberty unless this is in their best interests. Where it is necessary for an individual to be deprived of their liberty and that individual lacks mental capacity to consent to the arrangements for their care, then hospitals and care homes have a legal obligation to seek lawful authorisation for the arrangements for an individual's care.
- To issue Urgent Authorisation while applying for Standard Authorisation when required (both the Urgent and Standard Authorisations are on ADASS Form 1).
- To obtain authorisation from the Supervisory Body in advance of the Deprivation of Liberty, except in urgent circumstances, in which case

authorisation must be obtained from the Supervisory Body within seven calendar days of the start of the Deprivation of Liberty.

- To inform the family member or friend, of the person that they intend to request a Standard Authorisation from the Local Authority or are issuing an urgent Authorisation. This is because they believe that the person should be deprived of their liberty as they consider this person to lack mental capacity to decide on their care or treatment and they believe it is in their Best Interests to detain them for their own safety.
- To comply, once a DoLS Authorisation has been granted, with any conditions attached to it, as requested by the Best Interests Assessor (BIA) and recorded in the authorisation form signed by the DoLS Authoriser.
- To maintain effective communication and co-operation with the Best Interests Assessor (BIA), Mental Health Assessor (MHA), IMCA/Paid Representative, and Supervisory Body during the assessment process.
- To monitor whether the Relevant Person's Representative (RPR) maintains regular contact with the person as the RPR is empowered to raise any concerns with the supervisory body, or the Court of Protection. If the RPR is not maintaining contact, the supervisory body must be informed.
- To review the care plan on an ongoing basis, giving consideration to the involvement of an advocacy service in the review. It should be noted that Deprivation of Liberty can be ended before a formal review.
- No more than 28 days before the end of an authorisation make a request for this to be reassessed as appropriate (ADASS form 2).
- To maintain accurate and comprehensive records in particular to any restrictions and restraint used.
- Managing Authorities must note that a failure to identify a potential Deprivation of Liberty might be construed as a breach of rights. In such circumstances, if it is the opinion of the Local Authority DoLS service that this omission may constitute abuse, they must contact the relevant departments in the Local Authority (Safeguarding Adults Team/ MCA DoLS Team/ Care Management Team) to agree ongoing DoLS and safeguarding arrangements that ensure the relevant person is protected.
- To notify the Care Quality Commission of authorised Deprivations of Liberty.
- Notify the Supervisory Body of changes in circumstances.
- To raise a safeguarding concern for an adult deprived of liberty who does not lack mental capacity.
- The relevant person and their representative should be made aware of the types of questions/issues they can take to the Court as stated in the Code of Practice.
- The Managing Authority and the Supervisory Body should endeavour to resolve any concerns through mediation, or their own complaints procedures before the relevant person or their representative refer the matter to the Court. The Managing Authority and Supervisory Body are required to comply with any conditions imposed by the Court following a hearing.

- It is the responsibility of the Managing Authority to ensure that the relevant person and their representative is aware of their rights to apply to the court both before the authorisation is granted and afterwards and that they have the information required in order to make a referral to the Court.

2.5 Making an application for a DoLS authorisation

Where a health or care provider, referred to as a Managing Authority in the DoLS Code of Practice, reasonably believes that an individual may be deprived of their liberty, they must submit an application for a DoLS authorisation to the Local Authority. The application should be made by the registered manager where the person is in a care home or the ward manager where the person is in a hospital.

This must be submitted through completion of ADASS Form 1. Once completed and signed the DoLS application must be emailed to the authority where the person is ordinary resident, thus:

- In Southend - LibertyAdmin@southend.gcsx.gov.uk
- In Essex - dolsreferrals@essex.gcsx.gov.uk
- In Thurrock - dol.safeguards@thurrock.gov.uk

The DoLS application may include an urgent authorisation for up to 7 days (a further extension of 7 days may also be requested).

2.6 Key responsibilities of the Supervisory Body

- To co-ordinate, a dedicated Deprivation of Liberty Safeguards Service to undertake the work related to Deprivation of Liberty.
- To ensure there is a clear referral pathway for all Managing Authorities for all issues relating to DoLS.
- To recruit or commission assessors that have the necessary skills, qualifications and experience as outlined in the DoLS Code of Practice and related Regulations.
- To ensure there are sufficient numbers of assessors to undertake the volume of assessments required.
- To ensure that all staff have adequate training.
- To seek assurances that staff working for a Managing Authority or any other person who may have a duty of care towards adults receiving care or health services are appropriately trained in Deprivation of Liberty and Safeguarding.
- To ensure consistency and equality of access to, and outcomes from, Deprivation of Liberty Safeguards services.
- To have overall responsibility for granting or refusing authorisations for Deprivation of Liberty and to be responsible for signing authorisations.

- When giving authorisation for Deprivation of Liberty, to specify the duration of the Deprivation of Liberty, which cannot exceed 12 months.
- To attach appropriate conditions to the authorisation and make recommendations based on the best interests of the relevant person.
- To receive applications from Managing Authorities for standard authorisations of Deprivation of Liberty and renewal requests and to respond to applications within the prescribed timescales.
- Where appropriate to commission an Independent Mental Capacity Advocate (IMCA) and other relevant advocacy support as required.
- To commission the required assessments of the relevant person to ascertain whether or not they meet the qualifying requirements for a standard authorisation to be given.
- To give notice of the decision in writing to specified people, and to notify others by the most appropriate means.
- Where an authorisation for a Deprivation of Liberty has been granted by the Supervisory Body, to appoint a Relevant Person's Representative (RPR)/Paid Representative to represent the interests of the relevant person.
- To respond to requests to review an authorisation for Deprivation of Liberty.
- To ensure that DoLS have a recognised complaints procedure in place.

2.7 Third party requests

- The DoLS Service may receive referrals from a third party regarding an unauthorised Deprivation of Liberty – Standard DoLS Letter 2.
- The DoLS Service should keep a written record of the request.
- The DoLS Service should consider the issue with the Managing Authority and decide whether to pursue the request further and appoint a Best Interests Assessor to assess whether there is an unauthorised deprivation.
- Having received the Best Interests Assessor's report, the Supervisory Body records its decision using Standard Form 5 or Form 6. The DoLS Service will give copies of the Supervisory Body decision to the 3rd party, the relevant person, the Managing Authority and any IMCA.
- If the Deprivation of Liberty is occurring and is not already authorised the Managing Authority needs to issue itself an Urgent Authorisation using Form 1, or cease the Deprivation of Liberty immediately.
- The local authority DoLS service must also consider whether the failure to consider a request for assessment by the Managing Authority is an act or omission that constitutes abuse. If it is the opinion of the DoLS service that this act or omission constitutes a breach of rights, they must contact the relevant department in the Local Authority that manages the MCA DoLS service to agree ongoing DoLS and safeguarding arrangements that ensure the Person's rights are protected.

2.8 Authorisation of DoLS

Local Authorities will ensure that authorised signatories of DoLS are appropriate and that those who authorise DoLS have received appropriate DoLS training pursuant to their responsibilities.

2.9 Appeals to the Court of Protection about an authorised standard Deprivation of Liberty Safeguards application (s21A MCA)

The Court of Protection, established by the Mental Capacity Act 2005, exists to allow anybody deprived of their liberty the right to speedy access to a court that can review the lawfulness of their Deprivation of Liberty.

The following have an automatic right of access to the Court of Protection and can make an application:

- The Person who lacks or is alleged to lack mental capacity
- The donor of a Lasting Power of Attorney or their donee
- A Deputy appointed by the court
- Anyone named in an existing court order
- The person's appointed Representative under DoLS.

2.10 Deprivation of Liberty in a setting other than a hospital or registered care home

Individuals may be deprived of their liberty in settings other than registered care homes or hospital and nursing homes. This may include supported living settings, private homes or shared accommodation. It is unlawful for any individual to be deprived of their liberty, except where this occurs through a procedure prescribed by law and the individual has speedy access to the court for a review of the deprivation (ECHR Art 5(1) and Art 5(4)).

Applications should be made by the relevant Local Authority or Clinical Commissioning Group to the Court of Protection for the authorisation of deprivation of liberty in such settings. Determination of which agency is most appropriate to make the application to the Court may need to be determined on a case-by-case basis – the state authority with greatest responsibility for their care typically being responsible for the application. It is vital where both Local Authority and CCG are responsible for a care-package that there are no delays in appropriate applications to the Court.

2.11 Young people and DoLS

Children, under 18, whose care arrangements are attributable to the state (such as those in foster care) and whose care package amounts to a deprivation of their

liberty, will require an authorisation of any such Deprivation of Liberty from the Court of Protection, if aged 16 and over, or from the High Court if under the age of 16.

The arrangements for the care of the disabled child should be compared with a non-disabled child of the same age (see *RK v BCC, YB and AK [2011] EWCA Civ 1305*) – a parent cannot consent to the lawful deprivation of liberty of their child if the Local Authority has placed the child or arranged the child's care under their Children Act powers.

Where the arrangements for the care of a child/young person amount to a deprivation of their liberty, the Local Authority should (having firstly considered if the MHA (1983) or s25 CA (1989) can be utilised), make an application to the relevant court for authorisation. As the case law is constantly developing in this area, it is paramount that legal advice is obtained on a regular basis to ensure that practice is compliant with current legislation.

2.12 Deprivation of Liberty Safeguards training and accreditation

A wide range of staff, organisations, and stakeholders need to have a good working knowledge of the Mental Capacity Act 2005 and Deprivation of Liberty and be able to apply them both to practice. It is a requirement of the law that the 'Act must' be used when required.

Within Southend, Essex & Thurrock training is available for statutory, independent sector and voluntary organisations involved in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards through the Southend, Essex & Thurrock Local Authorities/Safeguarding Adult Boards. Opportunities include e-learning, workshops, and more detailed sessions combining MCA, DoLS and Safeguarding Adults. Further information on training opportunities can be found on the respective websites:

- Southend: http://www.southendlearningnetwork.co.uk/Services
- Essex: http://www.essexsab.org.uk/
- Thurrock: https://www.thurrock.gov.uk/keeping-safe-from-abuse/making-important-decisions

PART 3 – Reference Documents and Appendices

3.1 Reference Documents regarding Mental Capacity and DoLS

This section of the MCA & DoLS Guidelines contain some helpful reference documents, where you can read up more about related topics on the internet.

3.1.1 Mental Capacity Code of Practice

You can download the Mental Capacity Act 2005 Code of Practice here:

http://www.publicguardian.gov.uk/docs/mca-code-practice-0509.pdf

3.1.2 The Deprivation of Liberty Safeguards Supplement Code 2009

This is available here:

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_087309.pdf

3.1.3 (ADASS) DoLS Forms and Guide

The Association of Directors of Adult Social Services have developed DoLS forms and guidance and this can be found here: https://www.adass.org.uk/deprivation-of-liberty-safeguards-guidance

3.2 Case Law updates

For updates about case law as this develops, can be found here:

http://www.mentalhealthlaw.co.uk

3.3 Law Society Guidance on DoLS

The Law Society Guidance can be found at http://www.lawsociety.org.uk/support-services/advice/articles/deprivation-of-liberty/.

3.4 SET Partners Safeguarding Adults webpages

Webpages for respective SET partners that contains information about the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards can be found here:

Southend - http://www.safeguardingsouthend.co.uk/adults/mca.html
Essex - http://www.essexsab.org.uk/en-us/professionals/mcaanddols.aspx
Thurrock https://www.thurrock.gov.uk/keeping-safe-from-abuse/safeguarding-adults-agency-guidelines

3.5 Independent Mental Capacity Advocacy (IMCA)

Each Local Authority commissions their won Advocacy and IMCA service. For details of these, please refer to the local websites or respective Local Authorities, or their Safeguarding Adults Boards.

3.6 Mental Capacity Assessment (MCA) Form
3.7 Best Interests Decision (BID) Form
3.8 Independent Mental Capacity (IMCA) Referral

The most up to date versions of the mental Capacity Act (MCA) Form, Best Interests decision (BID) Form and the Independent Mental Capacity (IMCA) Referral can be found at:

http://dnn.essex.gov.uk/esab/en-gb/professionals/mcaanddols.aspx