The Mental Health Act, Mental Capacity Act (MCA) Including Deprivation of Liberties (DoLS)

Contents:

The Mental Health Act

In 2007 there were numerous changes made to the 1983 Mental Health Act. The primarily focus for the Mental Health Act 2007 is public protection and risk assessment.

The Mental Health Act allows a person to be admitted, detained and treated in hospital without their consent, this is often referred to as 'being sectioned'. In order for a person to be sectioned very strict criteria have to be met.

The person has to be suffering from a mental disorder of a nature or degree that would require assessment or treatment in that person's best interest, for their safety or the safety of others and they are unable or unwilling to agree to admission. The decision to section a person would require a Mental Health Act Assessment.

Three people involved in the Mental Health Act Assessment must agree that the criteria has been meet before a person can be detained. Usually this would be an Approved Mental Health Professional and two doctors, one of the doctors should already know the patient.

Approved Mental Health Professionals

The Approved Mental Health professional role was developed by the 2007 Mental Health Amendment. Prior to this the role was known as Approved Social Worker or ASW. The amendment to the Act broadened who could undertake the role beyond social workers to other registered Mental Health Professionals such as Nurses and Occupational Therapists who underwent specific training.

Their role is to bring a social and holistic perspective to the assessment. They are to ensure that the patients are properly interviewed and in an appropriate manner while having their rights protected. They are also involved in working with nearest relatives and carers.

What is Classed as a Mental Health Disorder?

The Mental Health Act defines the term 'mental disorder' as 'any disorder or disability of mind'. It includes mental health conditions such as:

- Schizophrenia
- Depression
- Bipolar disorder
- Anxiety disorder
- Obsessive-compulsive disorder (OCD)
- Eating disorders
- Personality disorders

It also includes any condition that there are changes in behaviour due to brain injury, or dementia or mental disorders due to drug use and autistic spectrum disorders. The definition includes learning disability only where it is associated with abnormally aggressive or seriously irresponsible behaviour.

You can only be sectioned if you have a problem with alcohol or drug use if you also have a mental health disorder.

What happens in an Emergency?

It all depends on where the person is:

- If the person is in a public place a police officer can detain them and take them to a place safety which will usually be a hospital or police station. The person with detained under section 136, they can be detained until an assessment has been completed which is a maximum of 72 hours.
- If the person is at home, the police can enter by force if necessary under section 135 and take them to a place of safety. They can be detained until an assessment has been completed which is a maximum of 72 hours.
- If the person is in a hospital, certain nurses can stop the person from leaving under section 5(4) until their doctor can decide to detain them under section5(2). Section 5(4) allows the nurse to detain the person for up to 6 hours. Section 5(2) allows the doctor to detain the person for up to 72 hours.

The Main Sections of the Mental Health Act

Section	What does it mean	How long does it last
2	**A person can be detained if:** • They have a mental disorder • They need to detained for assessment and possible treatment • It is necessary for the person safety or others	Up to 28 days This section cannot usually be extended. Before the end of the 28 days the person can be assessed and then sectioned under section 3.
3	**A person can be detained if:** • They have a mental disorder • It is necessary for the person safety or others • The treatment cannot be given unless detained in hospital	Up to 6 months The section can be renewed or extended by the Responsible Clinician: • For 6 months, the first time • Then 6 months, the second time • After that, for 12-month period., There is no limit to the number of times the responsible clinician can renew the section 3. The Responsible Clinician can discharge the patient before the end of the section.
4	**A person needs to be detained if:** • They have a mental disorder • It is urgently necessary that the patient is admitted and detained in hospital and • Waiting for a second doctor to confirm that they needed to be admitted to hospital would cause 'undesirable delay' A patient can be sectioned by only one doctor together with an approved mental health professional in an emergency and taken to hospital.	Up to 72 hours
5(2)	Applies to a voluntary patient or inpatient (including inpatients being treated for a physical problem). A doctor or other approved clinician needs to report to the hospital	Up to 72 hours

	managers that an application to keep the person in hospital 'ought to be made'.	
5(4)	Applies to a voluntary patient receiving treatment for a mental disorder. A nurse specially qualified and trained to work with mental health problems or learning disabilities can detain the person if they think that their mental health problem is so serious that: • The person needs to be kept in hospital immediately for their health or safety or for the protection of others, and • It is so urgent that it is not practicable to get a practitioner or clinician to provide a report to the hospital managers	Up to 6 hours, or until a doctor with authority to detain the person arrives, whichever comes first.

What role does the family have?

One member of the patient's family will be named as their 'Nearest Relative', this is not necessarily the patients next of kin. This can only be changed by the appointed person themselves or the court. The patient can apply to the court to get the nearest relative changed if they do not think they are suitable.

The nearest relative has many powers, they include stopping the patient from being placed under section 3 and applying for the patient to discharged from detention.

The Assessment

During the initial assessment, the assessor will discuss with the patient different aspects of their life, including:

- How they are feeling
- What are they thinking
- Do they self-harm or have suicidal thoughts
- What they do daily
- Medication
- Drug and alcohol
- Where are they living
- Do they live with others

The assessment can take place at home, in hospital or a place of safety.

Second Opinion Appointed Doctor (SOAD)

The second opinion appointed doctor service is there to help to safeguard the right of patients who are subject to the Mental Health Act. If a patient refuses treatment or is too ill or unable to give consent for another reason than a SOAD will be consulted.

Their role is to establish if the patient's treatment is appropriate and that the patients' rights and views have been considered. For example:

- If a patient has been receiving medication without consent under the Mental Health Act for 3 months, the SOAD will assess if the medication should be continued.
- If a doctor feels that a patient requires ECT but the patient is too ill to consent the SOAD will assess if the treatment is appropriate. ECT cannot be given to a patient who refuses consent, except in urgent circumstances.

Section 17 Leave

If a patient is detained under the Mental Health Act they may leave the hospital if the Responsible Clinician authorises it. The Responsible Clinician may place conditions on the leave, for example, where the person can stay and for how long. The Clinician can revoke the leave and make to person return to hospital at any time.

Appealing Against Detention

A person detained under the Mental Health Act may appeal against that decision to a Mental Health Tribunal (MHT) or to the hospital's managers.

The Mental Health Tribunal is a court that deals with cases relating to the Mental Health Act 1983. The Tribunal decides whether a patient can be discharged from their section and can decide about suitable aftercare and make recommendations about matters such as hospital leave, transfer to another hospital, guardianship and community treatment orders.

The court is made of a panel, which normally includes:

- A legally qualified chairperson
- A 'lay person' who has appropriate experience and qualifications in mental health
- An independent psychiatrist, who will speak to the patient and examine them before the tribunal hearing in certain circumstances, and when the patient request to see them

Independent Mental Health Advocate (IMHA)

If a person is detained they also have the right to see an Independent Health Advocate. They help patients understand their rights and provide help and support if they have any complaints.

A patient has a right to an IMHA if they are:

- Detained in hospital under a section of the Mental Health Act, but not under sections 4, 5, 135 and 136
- Under Mental Health Act guardianship, conditional discharge and community treatment orders (CTOs)
- Discussing having certain treatments, such as electroconvulsive therapy (ECT)

Community Treatment Orders (CTO)

If a person has been detained under the Mental Health Act and they are being discharged or being released on leave they may be place under a CTO.

A CTO means that when a patient is discharged they can go home but under certain circumstances, this is to ensure continuing protection for the patient and others. The CTO will stipulate the treatment the person will need to continue and the medication they must take. If the patient breaks the conditions of the CTO or is their condition worsens they can be recalled to hospital.

The patient has the right to appeal against the CTO through the Mental Health Tribunal and the have access to an Independent Mental Health Advocate.

Children

If a child is unable to consent or is too ill then the parent/s will consent on their behalf. A child would be considered to be competent to make their own decisions if they are found to have enough understanding regarding the proposed treatment. If they can demonstrate this they are deemed to be 'Gillick Competent'

Section 43 of the MHA 2007 amends section 131 of the 1983 Act so that in the case of patients aged 16 or 17 years who have the capacity to consent to the making of arrangements for their admittance to hospital or registered establishment for treatment for mental disorder on an informal basis, they may consent (or may not consent) to such arrangements and their decision cannot be overridden by a person with parental responsibility for them.

The Mental Capacity Act (MCA) 2005

The Mental Capacity Act 2005 is a law that protects and supports people who do not have the ability to make decisions for themselves. The act applies to people aged 16 and over in England and Wales. Northern Ireland has different laws around capacity.

Mental capacity is the ability to make decisions for yourself. People who cannot do this are said to 'lack capacity'. This might be due to illness, injury, a learning disability, or mental health problems.

The Deprivation of Liberty Safeguards are part of the Mental Capacity Act 2005 and only apply to people who are lacking capacity – these came into force in April 2009**.** The Deprivation of Liberty Safeguards have been written so that people who are staying in hospital or living in a care home should be treated or cared for in a way that means they are safe. They should be free to do the things they want to do.

The Mental Capacity Act applies to all people making decisions for or acting in connection with those who may lack capacity to make particular decisions. The staff who are legally required to have regard for the Code of Practice when acting in relation to a person who lacks, or who may lack capacity includes those who are paid to provide care or support e.g. Care assistants, home care workers, staff working in supported housing, prison officers and paramedics.

What is Mental Capacity?

Mental capacity is the ability to make decisions for yourself. People who cannot do this are said to 'lack capacity'. To have capacity a person must be able to:

- Understand the information that is relevant to the decision they want to make
- Retain the information long enough to be able to make the decision
- Weigh up the information available to make the decision
- Communicate their decision by any possible means, including talking, using sign language, or through simple muscle movements such as blinking an eye or squeezing a hand.

People should be assessed on whether they have the ability to make a particular decision at a particular time. The mental capacity of a person can fluctuate. As an example, there might be times of the day when a person is able to think more clearly.

What is Lack of Capacity?

- An individual lacks capacity if they are unable to make a particular decision
- This inability must be caused by an impairment or disturbance in the functioning of the mind or brain, whether temporary or permanent
- Capacity can vary over time and depends on the type of decision

What is Consent?

Consent to treatment is the principle that a person must give their permission before they receive any type of medical treatment or examination.

The principle of consent is an important part of medical ethics and the international human rights law.

It can be given:

- Verbally – for example, by saying they are happy to have an X-ray.
- In writing – for example, by signing a consent form for surgery.

Defining Consent

For consent to be valid, it must be voluntary and informed, and the person consenting must have the capacity to make the decision. These terms are explained below:

- **Voluntary** – the decision to either consent or not to consent to treatment must be made by the person themselves, and must not be influenced by pressure from medical staff, friends or family.
- **Informed** – the person must be given all of the information in terms of what the treatment involves, including the benefits and risks, whether there are reasonable alternative treatments and what will happen if treatment does not go ahead.
- **Capacity** – the person must be capable of giving consent, which means they understand the information given to them, and they can use it to make an informed decision.

If an adult has the capacity to make a voluntary and informed decision to consent to or refuse a particular treatment, their decision must be respected. This still stands even if refusing treatment would result in their death, or the death of their unborn child.

If a person does not have the capacity to make a decision about their treatment, the healthcare professionals treating them can go ahead and give treatment if they believe it is in the person's best interests. However, the clinicians must take reasonable steps to seek advice from the patient's friends or relatives before making these decisions.

How to give consent

Consent should be given to the healthcare professional directly responsible for the person's current treatment, such as the nurse arranging a blood test, the GP prescribing new medication or the surgeon planning an operation.

If someone is going to have a major medical procedure, such as an operation, their consent should ideally be obtained well in advance, so they have plenty of time to examine any information about the procedure and ask questions. If they change their mind at any point before the procedure, the person is entitled to withdraw their previous consent.

If they are able to, consent is usually given by patients themselves. However, someone with parental responsibility may need to give consent for a child to have treatment.

The Mental Capacity Act 2007 and Children

The Mental Capacity Act does not apply to children. If a child is unable to consent or is too ill then the parent/s will consent on their behalf.

A child would be considered to be competent to make their own decisions if they are found to have enough understanding regarding the proposed medical treatment. If they can demonstrate this they are deemed to be 'Gillick Competent'

Gillick competency refers to a legal case which looked specifically at whether doctors should be able to give contraceptive advice or treatment to under 16-year-olds without parental consent. But since then, they have been more widely used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

Since the Gillick case, legal, health and social work professionals continue to debate the issues of a child's rights to consent or refuse treatment, and how to balance children's rights with the duty of child protection professionals to act in the best interests of the child. Further court rulings, new legislation and revised guidance continue to amend the legal position.

Mr Justice Woolf:

"*...whether or not a child is capable of giving the necessary consent will depend on the child's maturity and understanding and the nature of the consent required. The child must be capable of making a reasonable assessment of the advantages and disadvantages of the treatment proposed, so the consent, if given, can be properly and fairly described as true consent.*"

Lord Scarman's comments in his judgement of the Gillick case in the House of Lords (1985) are often referred to as the test of "Gillick competency":

"*...it is not enough that she should understand the nature of the advice which is being given: she must also have a sufficient maturity to understand what is involved."*

He also commented more generally on parents' versus children's rights:
"*Parental right yields to the child's right to make his own decisions when he reaches a sufficient understanding and intelligence to be capable of making up his own mind on the matter requiring decision*."

Who Might Be Affected By The Mental Capacity Act?

Many adults with the following:

- Dementia
- Learning disability (especially severe learning disability)
- Brain injury / Stroke
- Someone suffering from trauma, loss and physical health problems
- Severe mental illness
- Temporary loss of capacity, for example because somebody is unconscious because of an accident or anaesthesia or because of alcohol or drugs
- Anyone planning for the future i.e. Advance decisions to refuse treatment in the event of an individual losing their capacity at some stage in the future – if an advance decision involves refusing life-sustaining treatment, it has to be put in writing, signed and witnessed but, otherwise, advanced decisions can be verbal.

The Five Main Principles of the Act

People who support or make decisions on behalf of someone who may lack mental capacity must follow five main principles:

1. Every adult has the right to make decisions for themselves. It must be assumed that they are able to make their own decisions, unless it has been shown otherwise.
2. Every adult has the right to be supported to make their own decisions – all reasonable help and support should be provided to assist a person to make their own decisions and to communicate those decisions, before it can be assumed that they have lost capacity.
3. Every adult has the right to make decisions that may appear to be unwise or strange to others.
4. If a person lacks capacity, any decisions taken on their behalf must be in their best interests. (The act provides a checklist that all decision makers must work through when deciding what is in the best interests of the person who lacks capacity – see below.)
5. If a person lacks capacity, any decisions taken on their behalf must be the option least restrictive to the person's rights and freedoms.

These five core principles must always be taken into account and ensure that no one is treated as unable to make a decision unless all practical steps have been exhausted and shown not to work

Simply we must all:

- Start off by thinking that everyone can make their own decisions.
- Give the person all the support they can to help them make decisions.
- No-one should be stopped from making a decision just because someone else thinks it is wrong or bad.
- Anytime someone does something or decides for someone who lacks capacity, it must be in the person's best interests -there is a checklist for this.
- When they do something or decide something for another person, they must try to limit the person's own freedom and rights as little as possible.

Making decisions in a person's 'best interests'

Anyone making a decision on behalf of a person they believe to lack mental capacity must do so in that person's best interests. To work out what is in the person's best interests, the decision maker must:

- Not assume the decision should be based on the person's age, appearance, condition or behaviour
- Consider if the decision can be postponed until the person has sufficient mental capacity to make the decision themselves
- Involve the person who lacks mental capacity in the decision as much as possible
- Find out the person's views (current or past), if possible, and take these into account
- Consider the views of others, such as carers and people interested in the person's welfare, where appropriate, and take these into account
- Not be motivated by a wish to bring about the person's death if the decision relates to life-sustaining treatment.

Once the decision maker has considered the relevant information, they should weigh up all the points and make a decision they believe to be in the person's best interests.

Assessing Capacity

Any assessment of a person's capacity must consider the following factors:

- Whether they are able to understand the information
- Whether they are able to retain the information
- Whether they are able to use or access the information while considering the decision.

The person has to be able to do all three to make a decision and, they must be able to have the ability to communicate that decision – this can include alternative forms of communication such as blinking an eye or squeezing a hand when verbal communication is not possible.

If the person being assessed is unable to do any one of the above, they are unable to make the decision for themselves.

Who assesses capacity?

Anyone caring for or supporting a person who may lack capacity could be involved in assessing capacity. This will include family members and carers. Important and/or more complex decisions may require specialist opinions from specialist nurses, speech therapists, psychologists or doctors but, even when used, may not be the only form of assessment. Who is involved depends on the individual circumstances.

Examples

Mr Ali, aged 82, lives with his son and family. He has always been very neat in his appearance but recently has not had many baths for fear of falling. He is increasingly confused, owing to vascular dementia, and has problems with urinary incontinence that may be helped by a daily bath.

You are a home carer responsible for providing personal care but he refuses to have a bath when you visit:

How would you assess capacity?
Who would you involve in the assessment?
Where might you seek advice?
Where would you record your decision?

We suggest that in this case you would tell your line manager in the home care service. They would be likely to discuss the problem with the family and any care manager or community psychiatric nurse involved in Mr Ali's support. Either of these may include Mr Ali's GP. An assessment of Mr Ali's capacity to make a decision about refusing a bath might draw on the views of the GP but it is unlikely that a consultant or psychologist would be involved in a decision of this nature. However, the family's views would be very relevant as they are the people that know Mr Ali best. All information should be recorded within Mr Ali's care plan.

One of your service users who is quite confused and requires personal care confides in you that she wants you to help her to make her will as she wants to make sure that most of her money goes to a charity supporting research into cancer. The service user has 2 sons who live quite a distance away and only visit occasionally.

How would you respond to the service user?
Who should you discuss this request with?
Should you tell her sons?

We suggest that you would talk to your line manager and that you and the manager talk to the service user together, advising he to discuss this with a solicitor – she may need help to arrange this.

We suggest that the service user be asked if she wants her sons to be told. However, this is confidential information so, unless she does or they have Lasting Power of Attorney, you should not inform them. The solicitor will do a common law test to establish the service user's capacity to make a will.

Planning For the Future

Lasting Power of Attorney

The Mental Capacity Act introduced a new type of power of attorney that replaced the Enduring Power of Attorney (EPA). It is known as a Lasting Power of Attorney (LPA). An LPA is a legal document. This allows people to choose someone who can make decisions about their health and welfare, as well as their finances and property, if they become unable to do so for themselves. The 'attorney' is the person chosen to make decisions on their behalf.

There are two types of LPA:

- Property and affairs LPA
- Personal welfare LPA

Property and Affairs LPA

A property and affairs LPA covers decisions about the person's finances and property. If there comes a time when they can't manage their finances anymore, the attorney will do this for them. This can include paying bills, collecting income and benefits, or selling their house. However, if the person wishes to they can restrict their powers, or place conditions on what they can do. It can only be used once it has been registered at the Office of the Public Guardian (OPG). The OPG is responsible for the registration of LPAs. It can then be used even while the person has mental capacity to deal with these things themselves.

Health and Welfare LPA

A health and welfare LPA allows the attorney to make decisions on the person's behalf about their health and welfare. A health and welfare attorney could make decisions about where the person lives, for example, or day-to-day care including their diet and what to wear.

It also can give the health and welfare attorney the power to accept or refuse life-sustaining treatment on the person's behalf. It's important to be aware of the effect this decision can have on any advance decision that the person has previously made. If they allow the attorney to make these treatment decisions for them, this will overrule any previous advance decision. If they choose not to give the attorney this power, their advance decision will still stand.

A health and welfare LPA can only be used once the form is registered at the OPG and you are in a position where you don't have the mental capacity to make decisions about your own welfare.

Who can make an LPA?

To make an LPA the person must be over the age of 18 and have the mental capacity to make this decision.

Who can be an Attorney?

Anyone can be chosen to be an attorney, as long as they are over 18. For a property and affairs LPA they cannot be bankrupt.

Most people will choose a relative or close friend, but you can also ask a professional such as an accountant or solicitor. A professional may charge for their time, an individual has to be named rather than an organisation or company. The person must also be willing and able to carry out the role. A replacement attorney should also be considered. A replacement attorney is the person who can make the decisions if the first choice attorney is no longer able or willing to be the attorney.

How an Attorney Acts

When making decisions, your attorney must follow the Mental Capacity Act. This means that they:

- Must act in the person's best interests
- Must consider past and present wishes
- Cannot take advantage to benefit themselves
- Must keep all of the person's money separate from their own.

If the attorney fails to comply, the LPA could be cancelled. If an attorney has taken advantage of the person, this will be investigated by the Office of Public Guardian and the person could be prosecuted. Having an LPA in place can therefore offer protection from potential future abuse.

How to make an LPA

To make an LPA you will need to complete an LPA form. There are separate forms for the two different types. You can choose to fill in a paper form, or do it online. Either way, the form needs to be printed, signed and sent to the OPG. Both include guidance notes which are extremely useful and should be read carefully.

Deputies and the Court of Protection

Deputies are appointed to make decisions for people who lack the capacity to do so themselves. This applies particularly in situations where formal arrangements have not been made – for example, if a person loses capacity and has not set up a Lasting Power of Attorney or an advance decision. A deputy is usually a friend or relative of the person who lacks capacity, but could also be a professional. To become a deputy you must apply to the Court of Protection. Deputies must make decisions in the best interests of the person lacking capacity. These might be about property or financial affairs, such as redeeming an insurance policy or selling a house.

The Court of Protection also has authority to make official decisions (called orders) about any healthcare, welfare or financial matters. For complex or ongoing financial decisions – or where a series of steps may be needed over a long period – the court can appoint a deputy to make decisions. Again, the deputy must always act in the best interests of the person who lacks capacity.

The Court of Protection does not usually appoint deputies to make ongoing decisions about someone's health and welfare. These decisions can usually be made in the person's best interests by those providing care and/or treatment. If there is a disagreement as to what is in the person's best interests or the decision relates to specified serious medical treatment, it may be necessary to ask the court to intervene. You do this by applying for what is known as a court order.

Safety Measures

The Mental Capacity Act established some significant safety measures:

- **Court of Protection** – a court that can make declarations about whether someone lacks capacity, and can make orders or appoint deputies who can act on behalf of someone who lacks capacity. The court has the final say on most decisions.
- **Public Guardian –** a public official whose duties include registering Lasting and Enduring Powers of Attorney (LPAs/EPAs), supervising deputies appointed by the Court of Protection and investigating concerns about the operation of a registered power or deputy. The Public Guardian is supported by the Office of the Public Guardian (OPG).
- **Independent mental capacity advocates (IMCAs)** – individuals who help people without capacity to express their views and wishes and, if needed, speak for them about the decisions that are being taken on their behalf. IMCAs mainly become involved in decisions about serious medical treatment or the person's long-term accommodation where it is provided by the NHS or a local authority. Local authorities and the NHS can also ask IMCAs to be appointed to help represent the person's views and wishes on decisions that are based on safeguarding the person without capacity, if it would benefit them and be in their best interests.
- **Clear guidelines for research** – designed for any research involving people who lack capacity. The research must be approved by an appropriate body. This body must also ensure that the research is safe and relates to the person's condition. It must also ensure that the research would be less effective if it involved people who had mental capacity.
- **Criminal offence of ill treatment or wilful neglect of a person who lacks capacity** – a person found guilty of this offence may be liable for up to five years in prison.

The code of practice for the Mental Capacity Act 2005

The code of practice for the Mental Capacity Act gives guidance on how the act should work on a day-to-day basis. It provides case studies and explains in detail the key features of the law.

The following people have a formal duty to follow the code of practice:

- Those working in a professional capacity
- People receiving payment for work dealing with people who lack capacity
- Anyone appointed as an attorney under an LPA
- Deputy appointed by the Court of Protection
- Someone doing research covered by the act.

Family, friends and other unpaid carers will find it helpful to use the code for guidance when making significant decisions for a person, e.g. about where they live.

Advanced Decisions and Advanced Statements

Advance decisions and advance statements ensure that a person's wishes are taken into account in the future. There are collectively as 'advance care planning'. The purpose is to enable a person to make choices and decisions about their future care, in case there is a time when they cannot make these decisions for themselves. This can ensure that they are not given treatment that they do not wish to receive, or that their family have power to act on their behalf if they wish them to.

What is an advance decision?

An advance decision gives someone the opportunity to make decisions now about specific treatments that they may not want to receive in the future. The purpose is to ensure that, if they are not able to make decisions about treatment or consent in the future, they are not forced to receive treatment that they would not want.

Treatment that can be refused includes life-sustaining treatment. For example, some people may write an advance decision to refuse a blood transfusion for religious or spiritual reasons, even if this will hasten their own death.

Advance decisions are legally binding as long as they fulfil certain requirements, and this means that they must be followed by doctors and other medical professionals.

What is an Advance Statement?

Advance statements are similar to advance decisions, but they are not the same thing. It is important to note that a person can make both an advance statement and an advance decision.
An advance statement can be made verbally, or they can choose to write it down, which can be better because it is a permanent record. An advance statement gives them the chance to make more general statements about their wishes and views for the future, whereas an advance decision is about refusing certain treatments. Often an advance statement is referred to as a 'statement of wishes and care preferences'.

An advance statement can be made to express their wishes on future care options, such as where to wish to live, or the type of care and support they wish to receive.

An advance statement can also be used to express other wishes and preferences not directly related to care. Examples include stating food preferences, such as being vegetarian or not eating seafood, or preference for having a bath over a shower. If there are particular religious or spiritual views, an advance statement provides an opportunity to ensure that any relevant values that they hold are taken into account by the people who make decisions for them.

Advance statements are not legally binding.

Will the doctor have to follow an advance statement?

An advance statement – unlike an advance decision – is not legally binding, so doctors and medical professionals do not have to follow it. However, it should still be taken into account by health and social care professionals when making decisions about care and treatment.

Will the doctor have to follow an advance decision?

All medical professionals, including doctors, will have to follow an advance decision. However, this is only when the advance decision is 'valid' and also 'applicable'.

- **Valid** – In order to be valid, an advance decision must have been made at a time when the person was able to make this decision. This is referred to as having mental capacity.

- **Applicable** – In order for the advance decision to be applicable, the wording has to be specific and relevant to the medical circumstances. If the wording is vague or there is a concern that it does not refer to medical conditions and/or practices that the person is actually experiencing, then the advance decision may not influence the doctors' decisions at all.

The advance decision must also:

- Be clear and unambiguous
- Have been made when the person were over the age of 18, and fully informed about the consequences of refusal of treatment, including the fact that it may hasten death
- Not have been made under the influence of other people
- Been written down and be signed and witnessed if it relates to refusing lifesaving treatment.

What an advance decision cannot do

An advance decision cannot be used to:

- Refuse treatment at a time when the person still has capacity to give or refuse consent
- Refuse basic care essential to keep the person comfortable, such as washing or bathing
- Refuse the offer of food or drink by mouth (but it can be used to refuse feeding by tube, for example)
- Refuse the use of measures solely designed to maintain comfort – for example, painkillers (which relieve pain but do not treat the condition)
- Demand specific treatment
- Refuse treatment for a mental disorder in the event that you are detained under the Mental Health Act 1983
- Ask for anything that is against the law, such as euthanasia or assisting you in taking your own life.

Deprivation of Liberty Safeguards (DoLS)

The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom. The safeguards should ensure that a care home and hospital only deprives someone of their liberty in a safe and correct way, and that this is only done when it is in the best interests of the person and there is no other way to look after them. DoLS does not apply to supported Living, applications for deprivation of liberty in supported living must currently be made directly to the Court of Protection.

Article 5 of the Human Rights Act states that 'everyone has the right to liberty and security of person. No one shall be deprived of his or her liberty [unless] in accordance with a procedure prescribed in law'. The Deprivation of Liberty Safeguards is the procedure prescribed in law when it is necessary to deprive of their liberty a resident or patient who lacks capacity to consent to their care and treatment in order to keep them safe from harm.

In 1997 a man with autism and learning disabilities was being cared for in a hospital called Bournewood. Because of his learning disability the man was not able to make the decision about whether he should stay in hospital or go home. His carers thought the man was not free to do all the things he wanted to do in hospital and his carers wanted him to come home. The hospital did not agree with the carers as the staff believed the man needed to be in hospital to get the care he needed.

The carers went to the Human Rights Court to decide who was right. The court agreed with the carers and said the hospital was wrong and had broken the law because the man had had his liberty taken away without any safeguards. This court case was called HL v the UK and is often called Bournewood. The Government made new rules to make sure that people can be cared for or treated in a way that is right. These rules are called the Mental Capacity Act 2005 Deprivation of Liberty Safeguards.

The Act is intended to assist and support people who may lack capacity and to discourage anyone who is involved in caring for someone who lacks capacity from being ***overly restrictive or controlling.*** The Act also aims to balance an individual's right to make decisions for themselves with their right to be protected from harm if they lack capacity to make decisions to protect themselves.

A Supreme Court Judgement in March 2014 made reference to the 'acid test' to see whether a person is being deprived of their liberty, which consisted of two questions:

- Is the person subject to continuous supervision and control? *and*
- Is the person free to leave? – with the focus being not on whether a person seems to be wanting to leave, but on how those who support them would react if they did want to leave.

If someone is subject to that level of supervision, and is not free to leave, then it is likely that they are being deprived of their liberty. But even with the 'acid test' it can be difficult to be clear when the use of restrictions and restraint in someone's support crosses the line to depriving a person of their liberty.

Each case must be considered on its own merits, but in addition to the two 'acid test' questions, if the following features are present, it would make sense to consider a deprivation of liberty application:

- Frequent use of sedation/medication to control behaviour
- Regular use of physical restraint to control behaviour
- The person concerned objects verbally or physically to the restriction and/or restraint
- Objections from family and/or friends to the restriction or restraint
- The person is confined to a particular part of the establishment in which they are being cared for
- The placement is potentially unstable
- Possible challenge to the restriction and restraint being proposed to the Court of Protection or the Ombudsman, or a letter of complaint or a solicitor's letter
- The person is already subject to a deprivation of liberty authorisation which is about to expire.

Who is affected?

The safeguards apply to vulnerable people aged 18 or over who are in hospitals, care homes and supported living, and who do not have the mental capacity (ability) to make decisions about their care or treatment.

A deprivation of liberty authorisation cannot be used if a person has the mental capacity to make decisions, so the person's capacity will be assessed as part of the process. The safeguards do not apply when someone is detained ('sectioned') under the Mental Health Act 1983.

What are the safeguards?

Those planning care should always consider all options, which may or may not involve restricting the person's freedom, and should provide care in the least restrictive way possible. However, if all alternatives have been explored and the hospital, care home or local authority administrating the supported living arrangements believes it is necessary to deprive a person of their liberty in order to care for them safely, then they must get permission to do this by following strict processes. These processes are the Deprivation of Liberty Safeguards, and they have been designed to ensure that a person's loss of liberty is lawful and that they are protected.

The key elements of the safeguards are:

- To provide the person with a representative
- To give the person (or their representative) the right to challenge a deprivation of liberty through the Court of Protection
- To provide a mechanism for deprivation of liberty to be reviewed and monitored regularly.

What is deprivation of liberty?

A recent court decision has provided a definition of what is meant by the term 'deprivation of liberty'. A deprivation of liberty occurs when 'the person is under continuous supervision and control and is not free to leave, and the person lacks capacity to consent to these arrangements'.

It can be helpful to think of restrictions of a person's activity as being on a scale, from minimum restrictions at one end to the more extreme restrictions – deprivations of liberty – at the other end. One large restriction could in itself be a deprivation of liberty (such as sedating a person for non-medical reasons) or many small restrictions could combine to create a deprivation of liberty. It is the amount of control that the care home or hospital has over the person that determines whether the person is being deprived of their liberty.

There have been several test cases in the European Court of Human Rights and in the UK that have clarified which situations may constitute a deprivation of liberty:

- A patient being restrained in order to admit them to hospital
- Medication being given against a person's will
- Staff having complete control over a patient's care or movements for a long period
- Staff making all decisions about a patient, including choices about assessments, treatment and visitors
- Staff deciding whether a patient can be released into the care of others or to live elsewhere

- Staff refusing to discharge a person into the care of others
- Staff restricting a person's access to their friends or family.

Restraint and Restrictions

The Mental Capacity Act allows restrictions and restraint to be used in a person's support, but only if they are in the best interests of a person who lacks capacity to make the decision themselves. Restrictions and restraint must be proportionate to the harm the care giver 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 harm
- Removing items from a person which could cause them 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
- Repeatedly saying to a person they will be restrained if they persist in a certain behaviour.

Such restrictions or restraint can take away a person's freedom and so deprive them of their liberty. They should be borne in mind when considering whether the support offered to a person is the least restrictive way of providing that support.

How is deprivation of liberty authorised under DoLS?

The Deprivation of Liberty Safeguards (DoLS) can only apply to people who are in a care home or hospital. This includes where there are plans to move a person to a care home or hospital where they may be deprived of their liberty. The care home or hospital is called the *managing authority* in the Deprivation of Liberty Safeguards.

Where a managing authority thinks it needs to deprive someone of their liberty they have to ask for this to be authorised by a *supervisory body*. They can do this up to 28 days in advance of when they plan to deprive the person of their liberty.

For care homes and hospitals the supervisory body is the local authority where the person is ordinarily resident. Usually this will be the local authority where the care home is located unless the person is funded by a different local authority.

The managing authority must fill out a form requesting a standard authorisation. This is sent to the supervisory body which has to decide within 21 days whether the person can be deprived of their liberty.

The supervisory body appoints assessors to see if the conditions are met to allow the person to be deprived of their liberty under the safeguards. They include:

- The person is 18 or over (different safeguards apply for children).
- The person is suffering from a mental disorder.
- The person lacks capacity to decide for themselves about the restrictions which are proposed so they can receive the necessary care and treatment.
- The restrictions would deprive the person of their liberty.
- The proposed restrictions would be in the person's best interests.
- Whether the person should instead be considered for detention under the Mental Health Act.
- There is no valid advance decision to refuse treatment or support that would be overridden by any DoLS process.

If any of the conditions are not met, deprivation of liberty cannot be authorised. This may mean that the care home or hospital has to change its care plan so that the person can be supported in a less restrictive way.

If all conditions are met, the supervisory body must authorise the deprivation of liberty and inform the person and managing authority in writing. It can be authorised for up to one year.

The person does not have to be deprived of their liberty for the duration of the authorisation. The restrictions should stop as soon as they are no longer required.

Conditions on the standard authorisation can be set by the supervisory body. These must be followed by the managing authority.

Standard authorisations cannot be extended. If it is felt that a person still needs to be deprived of their liberty at the end of an authorisation, the managing authority must request another standard authorisation.

The managing authority can deprive a person of their liberty for up to seven days using an urgent authorisation. It can only be extended (for up to a further seven days) if the supervisory body agrees to a request made by the managing authority to do this.
When using an urgent authorisation the managing authority must also make a request for a standard authorisation. The managing authority must have a reasonable belief that a standard authorisation would be granted if using an urgent authorisation.

Before granting an urgent authorisation, the managing authority should try to speak to the family, friends and carers of the person. Their knowledge of the person could mean that deprivation of liberty can be avoided. The managing authority should make a record of their efforts to consult others.

Supported Living Arrangements

If a person is receiving care in a supported living environment, arranged by the local authority, the Court of Protection must authorise the deprivation of liberty. This is the only route available. Anyone who feels that a deprivation of liberty in this setting may be required can ask the local authority to seek authorisation. The Court of Protection can also provide further guidance and information.

Care Homes and Hospitals

If a care home or hospital needs to provide care in a way that will deprive someone of their liberty, the registered manager of the care home, or the NHS trust or authority that manages the hospital (the managing authority) is responsible for applying for an authorisation for the deprivation of liberty. The managing authority should do this either when someone is about to be admitted, or when they are already in hospital or the care home. It is unlawful to carry out an action that will deprive someone of their liberty, without an authorisation for this action being in place.

The application for a standard authorisation will be made to the supervisory body. In England this is the local authority. In Wales this depends on where the person is receiving care. For care homes, the supervisory body is the local authority, and for hospitals it is the local health board.

The supervisory body will arrange an assessment to decide whether the qualifying criteria for DoLS are met, and will either grant or refuse an authorisation. In an emergency, the management of the hospital or care home may grant itself an urgent authorisation, but must apply for a standard authorisation at the same time. This urgent authorisation is usually valid for seven days, although the supervisory body may extend this for up to another seven days in some circumstances.
Before an urgent authorisation is given, steps should be taken to consult with carers and family members.

If you feel someone is being deprived of their liberty

If you feel that someone is being deprived of their liberty, speak to the person in charge. In hospital this may be a doctor, nurse or administrator; in residential care it will be the care home manager; for supported living this should be the social worker. Try to agree on changes that can be made so that the person's freedom is less restricted. If the manager of the care home or the person in charge in the hospital believes that what they are doing is necessary to keep the person safe, they must apply for a deprivation of liberty authorisation.

You may be in a situation where there is no deprivation of liberty authorisation in place for care in a care home or hospital, and the manager does not think that such an authorisation is necessary. In this case, you can approach the local authority (for any care in England and care homes in Wales) or the local health board (for a hospital in Wales) and ask them to investigate whether an unlawful deprivation of liberty has occurred. You should be able to find the health board's contact details at your local doctor's surgery or hospital.

How does the authorisation process work?

Once it receives an application for a standard authorisation, the supervisory body must arrange for an assessment to take place within 21 days, to establish whether the qualifying requirements for an authorisation are met for that particular person.

These include:

- **Age** – This confirms that the person is aged 18 years or over.
- **Mental health** – This decides whether the person is suffering from a mental disorder. Mental disorder is the term used in law to describe a set of mental health conditions, including dementia.

- **Mental capacity** – This determines whether the person lacks capacity to make their own decisions about treatment or care in the place that is applying for the authorisation.
- **Best interests** – This establishes whether there is a deprivation of liberty and whether this is:
    - in fact in the person's best interests;
      needed to keep the person safe from harm;
      a reasonable response to the likelihood of the person suffering harm.
- **Eligibility** – This determines whether the person would meet the requirements for detention under the Mental Health Act 1983; this would make them ineligible for a standard authorisation.
- **No refusals** – This determines whether the person has made advance decisions about their treatment, and whether authorisation would conflict with any decisions made by, for example, a court-appointed deputy or someone with Lasting Power of Attorney.

An authorisation for a deprivation of liberty cannot be granted unless all of these requirements are met.

Who can make the assessment?

The assessment must be made by at least two assessors – a best interest's assessor and a mental health assessor. The supervisory body appoints the assessors, who must have appropriate training and experience. The best interest's assessment must be carried out by someone who is not involved in that person's care or in making any other decisions about it. The best interest's assessor will be a qualified social worker, nurse, occupational therapist or chartered psychologist with the appropriate training and experience.

The mental health assessor must be a doctor (likely to be a psychiatrist or geriatrician) who is able to assess whether a person is suffering from a mental disorder and discuss with the best interests assessor how depriving the person of their liberty may affect their mental health. The assessors will report back to the supervisory body. If the assessment has determined that all of the conditions are met and that a deprivation of liberty would be in the person's best interests, the supervisory body will grant an authorisation. They can ask the managing body to make some changes so that the person's care is less restrictive.

Who can speak for a person being deprived of their liberty?

Everyone who is subject to an authorised deprivation of liberty must have a 'relevant person's representative'. The representative is appointed by the supervisory body authorising the deprivation. Often it will be a family member or friend, or other carer, and they would normally have been involved in the assessment.

The representative can gain access to documents about the decision and ask for a review of the decision, and should be informed if anything changes.

If the person has no immediate family or non-professional carer to support them through this process, the managing authority will inform the supervisory body. The supervisory body will then appoint a representative. This may be an independent mental capacity advocate (IMCA) whose role is to help the person with dementia.

The supervisory body and the managing authority at the care home or hospital should work together to ensure that the person and their representative understand the deprivation of liberty process, that they know their rights, and that they receive the right support when the authorisation process begins and once a decision has been made.

The representative must stay in touch with the person deprived of their liberty in order to fulfil their role and to protect the rights of that person. The managing authority has a duty to make sure that this happens.

How long does the authorisation last?

An authorisation should last for the shortest time possible up to a maximum of 12 months. The assessment on which the authorisation is based can remain valid for 12 months.

The managing authority and the supervisory body must:

- Make regular checks to see if the authorisation is still needed
- Remove the authorisation when no longer necessary
- Provide the person's representative with information about their care and treatment.

What is a review?

A review of a deprivation of liberty authorisation is a formal process that looks at whether the authorisation is still needed. This can take place at any time after the authorisation has been granted. It is up to the care home or hospital to make regular checks to see if the requirements for the authorisation are still needed, and they must inform the supervisory body if circumstances change.

This means that a review should take place if there is a change in circumstances, and also if the qualifying requirements are no longer met. Therefore, if the deprivation is no longer in someone's best interests, or if it is not managed in the least restrictive way, then this should be looked at again in a review. The person under the authorisation, or their representative or IMCA, can request a review if the situation has changed.

The supervisory body is responsible for carrying out the review, and for keeping everyone involved aware of the changes as they take place.

Examples

My wife has dementia and social services want to put her into a care home. She does not want to go and I want her to stay at home with me. Can they make her go into a home using the Deprivation of Liberty Safeguards?

Deciding that someone needs to go into a care home is a big step. Social services and other health professionals (like the GP and mental health nurses) should be working with you to discuss all the possible care arrangements that would be best for your wife. This should include looking to see if your wife has the ability (mental capacity) to decide for herself. If she does not have capacity, the professionals need to consider if there is a way that your wife can stay at home.

However, in some situations it is not always possible for everyone involved to agree on the best course of action. Social services can decide if it's in someone's best interests to go into a care home if they don't have the mental capacity/ability to decide for themselves, but they cannot force the person to move. If they did want to separate you from your wife against your wishes, a deprivation of liberty authorisation would not be enough and they would have to ask the Court of Protection for permission and a court order.

The care home has stopped my husband from going to the pub on his own because they say he drinks too much and can be distressing and dangerous to other residents when he has been drinking. Is this a deprivation of his liberty?

It could be. The care home should take steps to identify when a deprivation of liberty authorisation might be required and to consider any steps they can take to avoid it happening.

If the manager thinks that a person might need to be deprived of their liberty in their care home and this cannot be avoided, they have a responsibility to apply for DoLS authorisation. An assessment would have to be done by a best interest's assessor to see if he has the mental capacity to make the decision to go to the pub and if this restriction amounts to a deprivation of his liberty.

If he doesn't have the mental capacity and it amounts to a deprivation of his liberty, then the best interest's assessor would decide if it is proportionate to stop him from going to the pub for his own safety and for the safety of others. If it isn't, then the authorisation would not be granted to prevent him from going to the pub. The home would have to reassess the care plan to find a way of letting him go that is acceptable, for example by allowing him to go at a certain time with someone else who can encourage him to limit his drinking to a more reasonable level.