Decisions

The Mental Capacity Act 2005
&
The Deprivation of Liberty Safeguards (DoLS)

A series of blog posts by Stuart Sorensen
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The law as it applies in England & Wales

"All rights are freedoms (liberties). They include the freedom to do things, to make choices for example. They also include freedom from things like assault and other forms of exploitation or abuse. Every choice you make for yourself is an expression of your right to decide. Your service users have the same rights unless there is a legally justifiable reason to restrict them."

About the author

Stuart Sorensen's background is mental health nursing and as such he has a wealth of direct experience of working with people suffering from all forms of mental health problems. From early voluntary work with elderly people as a teenager to unregistered care assistant posts and then clinical practice as a qualified nurse Stuart has a real understanding of the issues faced by workers at all levels on a daily basis.

Stuart qualified as a nurse in the West Midlands 1995 and gained his post graduate diploma in Psychosocial Interventions (PSI) from Sunderland University in 2003. His wealth of practical experience allows Stuart to engage with a variety of service-users and learners/participants in training courses that have the feel of reality about them rather than the 'ivory tower' type of presentation that comes from reading a book.

Stuart is passionate about recovery from mental disorders and much of his clinical and training work has been based around helping people to recover from serious mental disorders such as schizophrenia. He is particularly interested in ways of ensuring that vulnerable service-users are protected whilst still retaining the right to make decisions. The subject of this pdf (decision-making and the right to self-determination) is especially important to Stuart because it is so significant for people suffering from dementia. Experience within his own family has left Stuart with a long-standing interest in dementia and the way that sufferers can be supported to maintain quality of life.

As a trainer Stuart is keen to help staff 'at the coalface' to find a balance between the conflicting (and seemingly impossible) rights of workers, carers and service-users. After years of experience as a nurse and clinical specialist, Stuart understands the difficulties and dilemmas facing workers on the front line because he has faced them too.

Stuart has extensive experience of delivering many aspects of training around care provision and human/civil rights including training around Balancing Rights and Responsibilities, the Mental Capacity Act and the Deprivation of Liberty Safeguards, Person-centred Planning and Maintaining Therapeutic Relationships, particularly in relation to Challenging Behaviour. He is also very experienced in delivering training on topics such as Introduction to Mental disorder, Safeguarding of Vulnerable Adults (SOVA), specialist training on mental health related issues and, of course, Deliberate Self Harm.

Stuart is very well versed in the principles of therapeutic risk and enabling activities that carry the risk of harm. In addition to nursing practice he has also written and delivered training nationwide on Risk Appreciation to mixed groups of inspectors from both the Health & Safety Executive (HSE) and the now defunct Commission for Social Care Inspection (CSCI). He has worked extensively for various county and borough councils and also provided training on safeguarding and on mental capacity and related legislation on behalf of both the UK and Scottish governments.

Please feel free to pass this pdf document around to anyone you think may be interested.

Outline of contents

As usual this 'outline' post is my current plan for the coming series of posts but it is likely to change a little as the series progresses. However the basic outline will be as follows:

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Decisions 2: Background

The Bournewood case (HL vs UK)

Back in 1997 an autistic man in his late forties was admitted to hospital following an episode of self-harm. The man, known as HL was unable to communicate with care workers (couldn't consent) and so a 'best interests' decision was taken to admit him under 'common law'. The justification for this was the common law 'doctrine of necessity', a legal principle that allows care workers and others to intervene in emergency situations where another person lacks the capacity to consent.

For example an unconscious person with breathing problems found lying in the street can be taken to hospital without consent because they are unable to give it. The paramedics who transported him would be seen to be acting in best interests - doing what most people would consider to be reasonable at the time.

Similairly common law allows hospital workers to admit people in emergency situations but they would not be entitled to detain that individual over time without seeking formal legal authority, for example under the mental health act 1983 (now amended by the mental health act 2007). This is important.

This means that it is unlawful to prevent people from leaving a hospital or care home without formal legal authority. The implications of this for countless people in care homes, clinics, surgeries and hospitals throughout UK are very far-reaching indeed.

Do you work with vulnerable people, perhaps suffering from dementia or other 'confusional states'? Do you work in learning disability services? Do you work in medical or other, more social settings where people are asked to consent to procedures? If so then the new legislation affects you. In fact it has been part of your formal duty of care since April 1st 2007. To ignore this legislation is to risk up to five years in prison.

The problem was not really with the initial admission (although that has been criticised). It was the lack of legal authority for what happened next that mattered so much.

HL was not allowed to leave the hospital. Nor were his carers allowed access to him and yet, because he was not detained under the mental health act 1983. This means that he had no right of appeal. The Euriopean Court of Human Rights said that this sort of 'de-facto' detention is unlawful and is in breach of article 5 of the European Convention on Human Rights (the right to liberty) and article 8 (the right to respect for private and family life). It took five months of legal wrangling to secure HL's discharge from Bournewood Hospital in Surrey.

Bear in mind that it takes the unanimous agreement of all 27 European member states to change the European Convention rights. It is way beyond the authority of any one doctor, social worker, nurse or other care worker.

Common law admission in emergency situations is acceptable. Continued detention without legal backing is not.

The interface between common law and civil rights, liberty, duty of care and the law concerning capacity has been a source of great confusion for the health and social care culture for decades. So, as a result of the Bournewood case the government brought in the Mental Capacity Act 2005 to clear up the confusion. However it was rushed through parliament and there wasn't time to include everything that was needed to resolve these problems. That's why the Deprivation of Liberty Safeguards came along later. The safeguards are still part of the Mental Capacity Act but they didn't receive royal assent until two years later. That's why we'll consider them seperately at the end. The 'basic' MCA relates to restrictions of liberty – the Safeguards deal with deprivation of liberty.

This may seem confusing at first but stick with it – all will become clear.

Let's consider a more common scenario in UK. I was in a residential care home not so very long ago training the staff there on the Mental Capacity Act when we got to the section covering locked doors. This is important as it outlines the rules about when doors can be locked and how to work with them legally.

The manager of the care home was there in the session and she said:

"It's alright Stuart, you can skip this bit. It's not relevant for us."

This surprised me so I asked her how the law relating to locked doors could possible be irrelevant to a residential care home.

"Our residents don't go out." She replied me.

"Why not?" I asked.

"Because the doors are locked." Was the reply.

The manager seemed surprised when I asked her why the doors were locked and so she helpfully explained..

"Because they're old!"

Remember the point I made above about needing legal authorisation to deprive a person of their liberty. So far as I'm aware growing old is not a crime and it doesn't warrant imprisonment. No court in the land would convict someone for being elderly. Nor is learning disabilities a crime.

The right to liberty

All UK citizens have the same basic civil rights. These are legal entitlements. This is why nobody can prevent you from leaving your home when you want to. The legal rights you have will not change simply because you grow older. Nor will they be taken away should you change your address. The residents in this care home (it's not unique by the way) have simply grown old and changed their address. They have not given up their right to liberty.

Toward the end of this series we'll talk more about deprivations of liberty such as this when we cover the Deprivation of Liberty Safeguards (DoLS). For now though I want to consider restriction of liberty only. This is less severe than deprivation but is no less of an issue.

*The Mental Capacity Act 2005 sets out the circumstances in which we can **restrict** an individuals liberty if they lack the capacity to make their own decisions but that's all. We need outside authorisation to **deprive** a person of their liberty.*

All rights are freedoms (liberties). They include the freedom to do things – to make choices for example. They also include freedom **from** things – assault and other forms of exploitation or abuse. In short every choice you make for yourself is an expression of your right to decide. Your service users have the same rights unless there is a legally justifiable reason to restrict them. Different situations require different responses but don't worry it's not so hard to understand if you get the basic point about the three types of situation in your head first.

Three types of legal status

Us Make their own decision	Bournewood gap Follow Mental Capacity Act 2005	Mental Health Act Follow Mental Health Act 1983/2007
People whose capacity to make the decision is not in doubt	People who are not detained under the MHA but who lack the capacity to decide	People who (because of a mental disorder) are deemed to present a risk to self, risk to other or are at risk through self-neglect.

Every decision we face at work involving service-users, residents or patients/clients will fall into one of these three categories. It's important to be clear about which category is which because it affects the whole legal situation.

The law giveth …. The law taketh away

Every UK citizen has the same basic rights in law unless the law removes them. The law will allow us to restrict a person's liberty in their own best interests if:

- **They lack the capacity to make this decision at this time;**
- **The restriction is proportionate in the circumstances;**
- **The restriction is in that person's best interests (not the best interests of the staff, the relative or anyone else).**

Also remember that a person's legal status changes depending upon the situation under consideration. For example:

- George knows what he wants for tea – **he's us**;
- George doesn't understand what to do about his will – **he's in the Bournewood gap**;
- George is suicidal – **cared for under the Mental Health Act**.

As you can see, the difference isn't to do with a change in George so much as a change in the subject we're considering. George could, at the same moment be detained in a psychiatric hospital because of his suicidal behaviour, need assistance under the mental capacity act to sort out his will and be perfectly capable of choosing what to eat from the hospital menu.

The reason that issues of capacity seem so confusing is that people often fail to understand this concept.

- **Nobody has capacity for every decision – just try deciding how to solve the problem of global conflict to see what I mean.**
- **Almost everybody has capacity to decide something – even if it's just that they feel cold.**
- **It is unlawful to decide that any conscious person lacks the capacity to make all decisions. That has been illegal in England and Wales since April 1st 2007.**
- **Even if they're unconscious we must consider the likelihood of them regaining capacity (consciousness) and making their own decisions before we 'jump in'.**

The rest of this series will focus upon helping workers to find the balance between the rights of their service-users to make decisions, their duty of care and the legal responsibilities we all have to take reasonable steps to protect vulnerable people from harm.

Decisions 3: Principles

The Mental Capacity Act is underpinned by five important principles. Everything that we do for or on behalf of people who may lack the capacity to make their own decision must take these into account. We'll look at them individually over the next few posts but for now let's just see what they are.

Don't be fooled by the fact that they appear to be both obvious and straightforward. In reality they represent a major change in the way that we must work with vulnerable people even though that's not always obvious at first glance.

Anyway – the five principles are:

1. ***An assumption of capacity;***
2. ***Help people to decide before stating that they cannot;***
3. ***People have the right to make decisions that might appear to be eccentric or unwise;***
4. ***Everything we do for people who lack capacity to decide must be in their best interests;***
5. ***Everything we do for people who lack capacity to decide must be the least restrictive intervention.***

It is true, of course that there appears to be nothing earth-shattering about these principles and in fact there isn't. These have been well established legal principles for decades in the UK. However as we shall see the health and social care culture has consistently ignored them for just as long.

Decisions 4: Assuming capacity

The first of the Mental Capacity Act's underlying principles is:

An assumption of capacity

This means that we need to begin by assuming that everyone we meet is capable of making this particular decision at this particular time unless we have reason to suspect otherwise. In other words that person is 'us' in relation to the 'three types of legal status' table we used earlier:

Three types of legal status

Us Make their own decision	Bournewood gap Follow Mental Capacity Act 2005	Mental Health Act Follow Mental Health Act 1983/2007
People whose capacity to make the decision is not in doubt	People who are not detained under the MHA but who lack the capacity to decide	People who (because of a mental disorder) are deemed to present a risk to self, risk to other or are at risk through self-neglect.

This might seem very obvious and reasonable (in fact it is) but it doesn't sit too well with common practice in a number of care environments. Let's look at an example.

When I was still a young man I worked as a care assistant in a Learning disabilities residential home. Looking back I can see a number of problems with the way the home was run but at the time, having come into a system that was already established, I thought that this was how learning disabilities establishments were supposed to operate. I didn't know any better.

One of the fundamental mistakes I used to make related to the residents' ability to make choices. This mistake covered all sorts of decisions from what to watch on the TV to whether or not they wanted to come on group outings to the local swimming pool.

The house was set in its own grounds in a beautiful part of Lincolnshire and the lawn and garden were nothing short of stunning. The home employed a full time groundsman to keep everything in good order and he did an excellent job. Consequently, many of the residents used to enjoy spending time sitting under the trees in the grounds or walking around the landscaped garden.

However this wasn't always possible. You see, along with all the other staff there, I would take it upon myself to stop residents at the door and expect them to explain to me why they were safe to go outside. If I wasn't completely satisfied then I would prevent them from doing so – this wasn't difficult because the doors were always locked and only the staff had keys. Only if I was happy for them to leave would I **let** them go outside.

The problem was that this was the wrong way around. I emphasised the word let in bold for good reason. You see it wasn't up to me to **let** people do anything.

We use the word 'let' a great deal in health and social care but that implies an authority we do not usually have. I can only let a person do something if I have the legal power to prevent them – and usually I don't.

It wasn't up to me to let people go outside into their own garden. They went because they had a right to and unless I had good reason to interfere with that they didn't need my permission at all.

A more recent illustration of this comes from the N. Cornwall Learning Disabilities Partnership NHS Trust inquiry that took place in 2006. There were 40 referrals to the POVA list (now the vetting and barring list) and many of them were to do with staff preventing people from using areas that they had a right to without good reason.

Whenever we are tempted to take control of other peoples' choices it's useful to begin by asking ourselves:

"Who put me in charge?"

Unless you can demonstrate that the individual lacks the capacity to make this particular decision at this particular time then nobody put you in charge. The person has a legal right to make their choices whether we like it or not.

Even if the person lacks capacity (in which case you may very well be 'in charge') you will still need to act in their best interests and that doesn't automatically mean doing what is best for the staff or for the relatives.

People have the right to occupy their own space, to make decisions about when they get up or go to bed, to choose who they spend time with and whether or not to involve themselves in activities. They also have the right to disagree with us and to ignore the preferences of family members just as you have. Your relatives have no right to tell you what to do (assuming you're an adult) and the same is true for your service-user with capacity.

Who put us in charge?

Decisions 5: Help to decide

The second principle of the Mental Capacity Act is that people must be helped to make their own decision before we assume that they cannot decide – that they lack the capacity to make this particular decision, or type of decision, at this particular time. This means that it is no longer acceptable simply to assume that an individual cannot choose without taking reasonable steps to assist them.

Reasonable help will vary depending upon the circumstances and could be anything from showing the care home resident the choice of sweets rather than simply naming them to taking them to the treatment centre so that they understand what it is that they are being asked to consent to.

Communication is an important issue here and it is no accident that many speech and language therapists are increasingly being asked to intervene in assisting people to understand the decisions that they have to make. This is similair to getting an interpreter in for someone who speaks a foreign language. If your service user spoke only French, for example it would be reasonable to contact a French speaking interpreter. Similairly if your service-user communicates best via British Sign Language or Makaton then it is reasonable for you to ensure an appropriate interpreter is available in the first instance and in many cases to develop your own abilities to communicate with them over time.

Some people need information presented to them in very simple terms. Actually the principle of 'simplification' is true for us all. It is only the 'degree' of simplification that varies. For example I would need a very simplified explanation before I could understand the rudiments of quantum mechanics. The fact that the topic in hand might be more straightforward, the benefits of medication for example, doesn't change the basic principle. We all need to have information presented to us in a format that we can understand.

We may need to take time to educate people before they can make their decision. For example, although I lack the capacity to decide how best to construct an internal combustion engine I could develop that capacity with sufficient education. The service-user who lacks the capacity to decide what to do about their financial affairs might be able to develop the capacity with the help of an appropriate advisor.

There are ethical considerations here too. The Mental Capacity Act code of practice is very clear that information should be presented fairly and in an unbiased manner. It is not uncommon for workers to influence their service-users' decisions by the way that they phrase things or by presenting only some of the information. Phrases like:

"You wouldn't like that would you?"

Are probably unhelpful. It is better to ask open questions such as:

"What would that be like?"

All of this might seem like a lot of extra work but in practice it probably isn't. Everyday decisions about basic care will require little or no extra time to show the service-user the choices rather than simply describe them. Some organisations make great use of pictorial charts for this very purpose and as a result the process is both quick and effective.

For more important or far-reaching decision such as consent to surgery this should be part of best practice anyway. Consent is not valid in respect of medical procedures unless it is informed and so most treatment centres are (or ought to be) already set up to ensure appropriate assistance is available.

It’s also important to ensure that the timing of conversations about consent is appropriate. for example, if a service-user’s medication makes them drowsy every evening ask them before you give the medication. If the person with diabetes is confused in the mornings until their blood sugar has been elevated then ask them later in the day.
Crucially, if the decision is not urgent and it is likely that the individual will regain capacity over time then you may well be obliged to wait until they can decide for themselves later. For example the individual with toxic confusion as a result of a chest infection will be able to make their own decisions following a few days treatment with the appropriate antibiotics.

All of this really should be ‘common sense’ (as are all the principles of the Mental Capacity Act 2005). However now that they are enshrined in legislation these principles take on another dimension for all care workers.

Decisions 6: Being eccentric

My favourite of the Mental Capacity Act's five principles is the third:

People have the right to make decisions that may appear to be eccentric or unwise.

To put it another way, the fact that a service-user disagrees with you doesn't mean that they don't understand.

For years care workers have assumed that patients, clients, residents or service-users who disagreed with their care plans and interventions simply didn't understand what they were trying to achieve. Of course sometimes this is indeed the case but equally, on many occasions it is not.

We have already noted the reality that individuals who have the capacity to decide can make their own decisions – that they have the right to self-determination. This is why you are free to disregard the advice of health professionals and others if you so wish. If this wasn't so no-one would smoke, off licences would go out of business and fast food outlets would long since have become a thing of the past.

The fact is that the right to make decisions is based upon capacity, but upon agreement. An elderly resident in a care home may be quite capable of deciding to drink the occasional glass of whisky in spite of his liver problem. It may be that health related consequences are far less significant to him than the pleasure he gets from his favourite tipple. If he has the capacity to decide then he also has the right to choose.

This doesn't necessarily mean that the care workers have to 'join in'. If the consequences of alcohol consumption reasonably conflict with the core aims of the service then the staff may choose not to help him obtain it. However this does not mean that they can take it from him.

This is rather like the situation that currently exists outside British general hospitals where patients have a perfect right to smoke but no staff member has a duty to help them to do so.

A major source of confusion here is that care workers often assume that they will be held responsible for the choices of their service-users. It's helpful to remember the following:

We are only responsible and accountable for the things that we lawfully can control.

Since we have no right to interfere with the rights of capacitous others we cannot be held responsible for their decisions. We are judged not upon the actions of others but upon our own actions in the circumstances we find ourselves in. For example you may not be accountable for your swallowing impaired patient's decision to eat toast but you would be accountable for your decision to walk away and leave them to choke to death whilst they did so.

The upshot of all this is that when a service-user makes a decision that you don't like the important issue is not agreement but capacity.

Capacitous individuals have the right to make their own decisions but they also have to accept the consequences of their decisions – just as you and I have to.

Decisions 7: Best interests

The Mental Capacity Act's fourth principle is concerned with 'Best Interests'. Essentially:

Everything that we do for or on behalf of a person who lacks capacity must be in** that **person's best interests.

This sounds obvious and almost unnecessary to say at first. After all most health and social care professionals would tell us that they already work in the best interests of their service-users. The difficulty comes when we begin to explain precisely what is meant by 'best interests'.

One very common misconception about best interests is that it means 'what the relatives say'. This is not reliable and indeed can land the worker in very real trouble. Consider, for example, the following hypothetical situation:

1. Julie is a registered nurse with around twenty years' experience in elderly care. She works in a nursing home.
2. Martha is an elderly lady with dementia whom Julie has just admitted into the home.
3. Julie completes a risk assessment and decides that the risk of using bedrails is greater than the risks associated with not using them. So she doesn't use bedrails.
4. Frank is Martha's son. He is horrified at the lack of bedrails and insists that Julie use them or else he will have her sued and the nursing home shut down.
5. Believing that Frank has the right to decide upon best interests Julie puts bed rails on the bed.
6. Martha falls later that night whilst trying to climb over the bedrails and fatally injures herself. She dies alone as a result of a head injury in the early hours of the morning.

Now let's look at the hypothetical case for the prosecution when Julie eventually appears in court as a result of her failure to protect Martha…..

1. Julie is a skilled nurse who understands the issues about risk asssessment, falls and bedrails
2. Julie has a duty of care to act in the best interests of the patient (Martha) – not Frank's best interests
3. Frank has no training in risk assessment and management and no duty of care to his mother
4. The decision about bedrails was Julie's to make based upon her professional understanding of risk management and the care of frail, elderly people. It was also her responsibility to make the decision in Martha's best interests
5. Julie failed to protect Martha from Frank's poor judgement
6. Julie failed in her duty of care to Martha
7. The fact that Frank disagreed with Julie about bedrails is not a defence. Disagreement from time to time is inevitable but good quality decision-making is about best interests, not about pleasing relatives.

Here's a slightly different, yet equally commonplace illustration.

Arthur has just been admitted into residential care. He is physically frail and has suffered several heart attacks in the past two years. As part of the admission procedure the registered manager takes his daughter to one side and asks:

"Would you like your father to be resuscitated if he has another heart attack?"

This question is still asked on a fairly regular basis but I'm sure that not everyone hears it the way that it is intended. Another way to interpret this question might be:

"Would you like your inheritance sooner or later?"

Perhaps a discussion with Arthur might have been more appropriate. Either way – the decision maker is not the relative - it's the person delivering the care or treatment. We'll talk more about how this works when we get more deeply into the role of muiltidisciplinary teams later in this series.

The Mental Capacity Act provides us with a checklist of things to consider from the perspective of the incapacitous person when we are deciding what to do in their best interests. Bear in mind though that there is a syntax – an order – to this.

Before we even begin to consider making a best interests decision on behalf of that person we must establish that they lack the capacity to decide for themselves. If they do have that capacity then they make up their own mind.

Anyway – in an abridged form the checklist looks like this:

"The particular factors in the checklist can be broadly summarized as follows:

- *Equal consideration and non-discrimination;*
- *Considering all relevant circumstances;*
- *Regaining capacity;*
- *Permitting and encouraging participation;*
- *Special consideration for life-sustaining treatment;*
- *The person's wishes and feelings, beliefs and values;*
- *The views of other people.*

It is important to remember that the checklist does not define best interests nor give an exhaustive list of factors to be taken into account. Rather it refers to factors that must always be considered in determining what is in a person's best interests. Not all the factors in the checklist will be relevant to all types of desires or actions, but they must still be considered if only to be disregarded as irrelevant to that particular situation."

Mental Capacity Act 2005 Code of Practice

As we can see then the determination about Best Interests under the Act is much bigger than simply 'what we've always done' or 'what the relative says'. We need to think carefully about what we decide for people who lack the capacity to decide for themselves. Often this will involve taking advice from/discussing situations with other members of the multidisciplinary team.

However if you are the person delivering the care or treatment then the responsibility for that decision will remain with you. Just as the relative cannot make the decision for you, neither can another professional although you are expected to listen seriously to the advice and opinions of appropriate others when you decide.

Always remember that:

"The decision maker is the person delivering the care or treatment."

Having made that point though there is a very real case for balance (thanks Marllo for pulling me up on that) and so I'd like to put the other side of the coin to you as well. It is true that the decision-maker is the person delivering the care or treatment but the decision-maker isn't expected to make their decision all alone. If you have a decision to make you will sometimes need to get advice from others, including professional staff, unqualified workers, friends and relatives. The fact that none of these people can tell you what you must do doesn't prevent them from expressing an opinion – nor does it prevent you from listening to their views.

Actually the Best Interests checklist (outlined above) makes it clear that you must. In many cases the information that comes from care workers, relatives or others is absolutely vital to the process. You don't have to do what they suggest but, if challenged (and you may well be) you will need to be able to say why you thought your plan was better than the other person's. For example, if you disagree with the doctor's plan to stop someone smoking you might need to be able to point out why it would have been unlawful to prevent them in the circumstances or why, on balance, the distress of nicotine withdrawal was more harmful to this person than the effect of continuing to smoke during his/her final days of life.

This is often where the information from relatives can be extremely helpful. Too often care workers make decisions based entirely upon clinical prognoses and medically orientated care plans that tend to disregard the 'humanity' of the people we care for. Friends and relatives can be a powerful force for good in that they are able to remind us of the more individual nature of our service-users. The information provided by families can be remarkably helpful, especially since they may well know the individual best and often have their best interests at heart (even if they don't know the ins and outs of your job).

The idea here is to be balanced. You may be the decision-maker but that doesn't mean that others cannot contribute to your understanding of the situation.

There are just a few occasions when relatives and other professionals really can tell you what **not** to do (**they can never tell you what you must do**). They will be covered later in this blog series when we look at Lasting Powers of Attorney, Advance Decisions and the role of the Court Appointed Deputy.

There's a longer account of the MCA Best Interest Checklist in part 12:

http://stuartsorensen.wordpress.com/2010/06/18/decisions-12-after-assessment/

Decisions 8: Least restrictive intervention

Everything we do for or on behalf of a person who lacks capacity must be the least restrictive of their basic rights and freedoms.

This, the fifth principle underpinning the Mental Capacity Act 2005, cuts right to the heart of the act and the reason for it's existence at all. The Bournewood case discussed earlier was an example of overly restrictive intervention by 'a process not proscribed by law'. Basically the actions of the staff as they 'exercised complete control over HL's care and movements' went far beyond what was necessary in the circumstances.

Principle 5 reminds us that we should only restrict an individual's basic rights and freedoms if it is necessary and legally justifiable. However the principle is about the 'least' restrictive intervention necessary, not 'non' restrictive intervention.

If it is truly necessary then we can and in many cases must restrict a person's liberty. The person must lack the capacity to decide and the restriction must be both proportionate (not a hammer to crack a nut) and in that person's best interests.

The bit that many people overlook with this principle is the fact that it is written in the plural, not the singular. It's not just the person's right and freedom – it's rights and freedoms.

All your freedoms are rights – they're liberties. The choices you make from deciding whether or not to have caffeine in your coffee to where to go on holiday are freedoms. As we have said before in this series your service user has the same rights to make choices, the same freedoms and liberties, as you have. The law giveth.

If you need to interfere with your service user's liberty to go outside that doesn't necessarily mean you can prevent their visitors from coming to see them as well. That might be necessary but if it is you need to be sure that there's a good reason – that it's proportionate. The law taketh away but only when we can justify the restriction.

Actually major restrictions might well cross over into deprivation of liberty anyway which requires a different approach. We'll consider that toward the end of the series when we cover the Deprivation of Liberty Safeguards (DoLS). Deprivation of liberty is different from restriction because it's more serious or severe. It also needs outside authorisation from specially trained assessors.

For now all we really need to say is that if you need to restrict a person's liberty then be sure you restrict it no more than is necessary:

The least restrictive intervention.

Decisions 9: A new offence

Since April 1st 2007 the code of practice that accompanies the Mental Capacity Act 2005 has been part of our statutory duty of care. That means that all workers who deal with people who may lack capacity have a legal duty to abide by it. Failure to do this is a criminal offence.

The new offence, created by the Act, comes in two parts. These are ***Wilful Neglect*** and ***Ill Treatment*** of a person who lacks capacity.

Let's look at these individually.

Ill Treatment

This is fairly straightforward to understand. It relies upon the existing definitions of abuse in England & Wales which are:

- Physical
- Sexual
- Financial
- Psychological/emotional
- Discrimination
- Institutional/environmental
- Neglect

If you commit any of these forms of abuse in respect of a person who lacks mental capacity then you will be guilty of ***ill treatment of a person who lacks capacity***.

All people who have dealings with people who lack capacity are liable to prosecution under this offence.

Wilful Neglect

The second offence if ***wilful neglect*** only applies to those of us who have a duty of care toward incapacitous people. This is because a person cannot be guilty of neglect unless they had a responsibility in the first place. Duty of Care then is the guiding principle behind all cases of neglect, including wilful neglect.

So what do we mean by ***wilful*** neglect?

Wilful implies deliberate intent and in relation to this offence is interpreted in two basic ways:

1. The person understood their responsibilities under the Mental Capacity Act and wilfully disregarded them;
2. The person had a duty of care toward the service user (which included the Mental Capacity Act 2005) and wilfully chose not to learn about it.

Either way, if you have a duty of care toward people who may lack capacity (for example people with dementias, learning disabilities or other confusional states) then you are subject to the new code and the new offence applies to you. Failure to learn about your new duties is not a defence. That is ***wilful neglect*** in itself.

Upon conviction under the new offence there are a number of possibilites:

- Up to 5 years imprisonment depending upon the nature of the offence;
- A fine (there is no maximum tarrif for fines in respect of this offence);
- Imprisonment **and** a fine;
- Inclusion on the Independent Safeguarding Authority's 'Vetting & Barring List' which effectively ends your career with vulnerable people.

These penalties are the same for offences under the Mental Capacity Act as they are under any other aspect of safeguarding (SOVA) legislation in England & Wales. This is because the Mental Capacity Act 2005 is really another layer of safeguarding protection for people who lack capacity. It's part of the same general 'stable' of legislation as the Safeguarding of Vulnerable Groups Act and the earlier Care Standards Act.

Clearly if workers are to be bound by the new legislation they need to know about it. This is why the government funded training through every local authority in England & Wales and offered that training free of charge to every care provider. The free training continued well into 2009. It was provided partly to ensure that everyone knew about their new responsibilities but arguably also to remove any possible defence that the worker did not know what their duties were. The training was offered but it was always the responsibility of individual providers and professionals to attend.

It is unfortunate that so many workers still have not attended the training that was available. I think that this is partly because of the Act's title. Many people who do not work in mental health services heard about the training but read no further than the first two words. They read

"The Mental….."

and then lost interest because they thought that it didn't apply to them. Actually nothing could be further from the truth.

Personally I'd have preferred it to have been called 'The Decison-Makers' Act 2005' because that would have made it clear to all care workers that it affected them too. However – it is what it is.

I have heard many workers claim that they are not responsible for their lack of understanding because their employers didn't send them on the courses that were offered. To an extent (but only to an extent) this defence might appear reasonable for non-professional workers (support workers and health care assistants for example). However professionally registered staff (doctors, nurses, social workers, occupational therapists etc.) are considered to be autonomous professionals with a professional responsibility to keep themselves updated. For these people to claim lack of awareness is to admit to ***wilful neglect*** as described above.

Whether you are professionally registered or not you cannot use ignorance as a defence in respect of charges of ***ill treatment***. All British citizens are expected to understand what is meant by abuse and to abide by the law.

Decisions 10: Here and now

When assessing an individual's mental capacity it is important that we confine ourselves to assessing that person's ability to make this particular decision (or type of decision) at this time. This is what the Act means when it refers to **'time and decision specific'** assessment.

At first glance this seems obvious and clearly reasonable. However on closer inspection it brings up a number of issues relating to 'established practice' that need to change. It also provides many workers from support workers to nurses, social workers and many others with a very real source of anxiety. Here's why.

In the past capacity decisions tended to be made by certain professionals such as psychogeriatricians or psychologists. One typical approach would be to ask a doctor to come and assess a service-user's capacity, not in relation to a specific issue but 'globally'. This would be done using one of several techniques, the most common in UK being the Mini Mental State Examination (MMSE).

The MMSE is a reasonable tool to assess cognitive deficit and is helpful in diagnosing certain conditions such as dementia but it is not an assessment of capacity. Diagnosis is not the same as capacity. For example, as I type the famous author Terry Pratchett has a diagnosis of Alzheimer's dementia but he is still sufficiently capacitous to go on writing novels. The fact that a person has a particular diagnosis does not tell us anything about their capacity to make particular decisions. The MMSE is not decision specific unless the care and treatment being offered relates to the service-user's ability to count backwards from 100 in 7s or to name the current Prime Minister.

The MMSE does not inquire into preferences of diet, whether or not a person understand how to cross a road safely or what time they would like to go to bed. These are the sorts of questions that must actually be assessed on a day to day basis when we are making decisions about a person's capacity.

The other major problem with 'global' assessments of capacity (apart from the fact that they do not asses capacity in the first place) is that they are not time specific. A psychogeriatrician's assessment at the start of the month will have little bearing upon the service-user's day to day decision-making capacity at the end of the month. So unless we can persuade the Dr to visit each service-user every mealtime to assess their capacity to choose between carrots and peas we have to use a different system.

Fortunately the Mental Capacity Act provides us with just such a system and, although unfamiliar to many it is very straightforward and in fact reflects what we've all been doing since early childhood anyway. You see assessing capacity is not difficult in itself so long as you understand it – and also understand what we are NOT expected to assess just as clearly as what we are expected to assess.

The Mental Capacity Act is clear….

"The decision maker is the person delivering the care or treatment"

This means that the support worker who decides that Albert needs a bath is responsible for assessing whether or not Albert has the capacity to consent to that bath. If he or she decides that Albert does not have the capacity to consent to that bath then the support worker is also responsible for deciding whether or not the bath would be in Albert's best interests.

This may seem unfamiliar when it's written down like that but actually that is precisely what has happened day in and day out in practice for decades in health and social care settings. Nobody calls the GP every time they think a resident in a care home might need their hair washed – they just decide. What the Mental Capacity Act does for us is it provides us with a way to show that our decisions make sense and gives us the legal backing to be free from prosecution for assault so long as we can justify our actions.

Part 5 of the Mental Capacity Act is subtitled 'Protection from liability' and deals with just this issue, ensuring that care workers can do what is necessary so long as they can show that the individual lacked capacity and that their actions were both proportionate and in their best interests. This is very empowering for care workers because it allows them the respect they deserve in making day to day decisions and provides them with legal protection at the same time.

Let's look at what we mean by mental capacity.

What is mental capacity?

Simply put mental capacity means the ability to make your own decisions – to decide for yourself. It is assessed using a particular process that looks unfamiliar when written down but in practice really reflects what we all do every day anyway. It's a two part test that follows a set pattern:

Part 1: The 'diagnostic' threshold

First we need to decide:

1 Is there an impairment or disturbance in the functioning of mind or brain?

2 Is that impairment or disturbance serious enough to impair decision-making?

This is there to ensure that there is a real reason to get involved in assessing capacity in the first place. For example an unconscious person would have an impairment in functioning but someone who was asleep would not. It would be more reasonable to wake the sleeping person or to wait until they woke – then they could make their own decision. Similairly eccentricity is not an impairment whereas toxic confusion due to a urinary tract infection would be.

We mentioned Alzheimer's dementia earlier. This is an impairment in the functioning of both mind and brain (we'll get into the difference between the two later when we cover DoLS). However it may not necessarily be sufficient to impair decision-making, particularly during the earliest stages of the disease or during 'lucid intervals'.

So before we go on to actually assess capacity itself we need to be able to answer 'yes' to both these questions. Otherwise we simply stop and the person makes their own decision whether we agree with it or not.

Part 2: The functional test of capacity

The person will be unable to make the particular decision if after all appropriate help and support to make the decision has been given to them (principle 2) they cannot:

1 understand the information relevant to that decision;

2 retain that information;

3 use or weigh that information as part of the process of making the decision;

4 communicate their decision (whether by talking, using sign language or any other means).

In order to have mental capacity about this particular issue at this particular time the person must be able to do all four of the above. If they cannot perform any one of the four tasks above they lack the capacity to make this decision at this time and the decision-maker then has to decide what will be in their best interests. Will they put Albert in the bath or won't they? Will the surgeon perform the operation or won't he?

This is the point at which many people protest and say that this seems easy on paper but actually it's much harder than that. I understand their point but I think it's not so hard so long as we're clear about what we're assessing and what we're not.

Remember that the decision-maker is the person delivering the care or treatment. This means that everyone is responsible for their own work decisions but ONLY for their own decisions. The care assistant might be responsible for assessing Albert's capacity to decide whether or not to have a bath but he would not be expected to assess Albert's capacity to consent to a course of antibiotics. That would be the job of the doctor who prescribed them.

So long as the care assistant understood what it meant to have a bath he can tell whether or not Albert does.

People often think that unless they know the person extremely well they cannot assess capacity. This is not so important as understanding the question at hand (which is why the decision-maker is always the person delivering the care or treatment) and we will go through the process to demonstrate how familiar it really is in practice in the next post.

For now it's enough to recognize that:

- Capacity is assessed on a person's ability to make a particular decision (or type of decision) at a particular time;
- The decision-maker is the person delivering the care or treatment;
- The MMSE is not an assessment of capacity and was never designed to be;
- The worker needs to know their job in order to be able to assess mental capacity;
- People who do not 'know' that particular job cannot assess a person's capacity to consent to it. This is why a psychogeriatrician cannot assess an individual's capacity to consent to a pension plan. That's the task of the financial advisor.

Decisions 11: The assessment

I said in the previous post that assessing capacity, however unfamiliar it might first appear is actually something that we've been doing for years. I also said that it is not so important to know the person we're assessing as it is to understand the question we're asking them to consent to.

Assessment decisions (outside of court processes which are a little different) are only ever made in relation to a procedure that we need the service-user to consent to.

I'm going to use a very simple illustration to make my point and then relate it to more complex decisions. Please bear with me.

Remember that the functional assessment is based around the person's ability to:

1 Understand the information relevant to the deciison;

2 Retain that information long enough to decide;

3 'Use and weigh' that information as part of the decision-making process;

4 Communicate the decision.

When I first began researching this process of assessing mental capacity my little girl was three years old. In order to test how simple it is to assess another person's capacity I created several situations where she could catch me 'getting it wrong' to see if she could do it. I didn't discuss capacity directly with her – she was only three after all. I simply acted as though I lacked the capacity to perform the stages. She got them all.

Here's an example – one of these 'tests' involved 'Bratz' dolls. These toys represent four distinct individuals from different racial groups, each with their own 'personalities' and crucially, their own names. One of them is called Jasmin and another is called Chloe.

Whilst playing with my daughter I picked up Chloe and said:

"Hello, I'm Jasmin – what should we do today?"

My daughter instantly corrected me and pointed out that the other one was Jasmin – I'd picked up Chloe. She was able to see that I hadn't understood the information relevant to the decision because she understood the information herself.

But the example I really want to use involves my own childhood. I don't know anything about you, the reader, so I can't use your life history – otherwise I would. But as I go through this illustration from my childhood please relate it to an example from your own youth. Then we'll relate the whole thing back to health and social care practice.

In 1976 I was 11 years old. That was the year when the summer was so hot that paving stones cracked and water was so scarce people were forced to queue at standpipes in the streets with plastic bottles. Many grown ups were desperately worried about the situation but I didn't care. Along with my friend Graham I spent the long summer days playing cricket in the local churchyard (since someone had very kindly organized to have all the gravestones moved to the boundary walls years before).

So imagine the scene – it's 1976 and two 11 year old boys are talking in the schoolyard. I say to Graham:

"Graham, would you like a game of cricket after school?"

Graham replies:

"Yes – I'll bring the football."

At 11 years old I would have known that Graham hadn't understood the question because I knew what it meant to play cricket and I knew that it didn't involve a football. I could tell this because I knew what I had proposed.

Crucially – it would have made no difference whether or not I knew Graham – cricket wouldn't have involved footballs either way and so I'd have known that he didn't understand.

We don't need to know the individual half so much as we need to understand the question.

What if I'd asked Graham if he wanted a game of cricket and half way through his reply he asked me to repeat the question? He'd have forgotten the question and I'd know that because it would be obvious. Again I need only to understand what is proposed – not necessarily to know much about Graham.

Let's say I said something more complicated:

"Graham would you like a game of cricket tonight? If so bear in mind that my grandfather is coming round for tea and my mother says that I can't go out to play cricket until we've finished. And she'll probably make me do the washing up as well – you know what she's like. So I know I usually meet you in the churchyard at half past four but it'll be nearer half past five or maybe even six O'Clock. So I'll tell you what, don't meet me in the churchyard – I'll come and knock on your door as soon as I can – it'll be between half past five and six O'Clock."

Imagine that Graham replies:

"So you'll knock on my door between half past five and six because you can't come out until you've finished washing up after you've had tea with your grandfather and so you won't make it to the churchyard at half past four as usual. OK – I'll meet you in the churchyard at half past four."

Clearly Graham had understood what I said (he repeated it back to me) and clearly he'd retained the information. But he didn't use the information and it would have been obvious to me at 11. It would have been equally obvious to you because so long as you know what has been discussed you know whether or not the other person has taken it into account. Once again we need to understand the issue at hand much more than we need to understand the individual.

Or finally let's assume that I ask Graham about a game of cricket and he simply refuses to answer. That's very obvious and again, it's not necessary to know very much about Graham (assuming you know he's not deaf) to know that he is either unwilling or unable to communicate his decision.

At 11 years old I could assess Graham's capacity to consent to a game of cricket and so could you, not because you know Graham particularly but because you know what cricket means (assuming that you do).

If you don't know that cricket doesn't involve a football you can't perform the assessment and that's why the decision-maker is the person delivering the care or treatment. The assumption is that they will know their own job and so will understand the responses they get from the person better than anyone else. That's why a doctor can't assess someone's capacity to consent to a pension scheme. The Doctor isn't trained in financial matters and doesn't understand the issue. The appropriate person would be the financial advisor.

Now let's relate this to clinical practice. These days, in practice I make much more complex decision than whether or not Graham can consent to a game of cricket. My clinical specialty involves recovery from serious and enduring mental disorders and I use, among other things, a technique known as cognitive behaviour therapy with people experiencing delusions, hallucinations and thought disorders. That's much more involved than a game of cricket.

However the same principles apply to my job and also to yours. I can assess a person's ability to consent to CBT with psychosis at 45 years old just as I could assess someone's ability to consent to a game of cricket when I was 11. This is not because I'm particularly gifted when it comes to understanding people – it's because I know my job today just as well as I knew what cricket meant then.

However unfamiliar this might seem at first glance you are capable of assessing capacity around your job (be it basic care or complicated therapy) because you know your job. Nobody else can do that assessment for you because:

- It's your job – and you know it best;
- They're not there when you perform your intervention;
- It's your duty of care, not theirs.

So don't panic. In reality this is a way of writing down what you've always done and the only thing that changes is you now have a legal backing to support you in it. Let's face it – it's not as though the GP would have taken the rap for your mistakes in the past even if it had been their assessment you'd relied upon. This makes you safer but it does take a little getting used to.

When you make your decision you do have to take into account the opinions and advice of others – that's important. That's what multi-disciplinary teams are all about and the advice and opinions of carers, relatives and other professionals is always worth considering but it doesn't change the fact that if you're 'Johnny on the spot' you are the decision-maker because you're there.

I've created a short video explaining the assessment process. You can access it here:

http://stuartsorensen.wordpress.com/2010/06/25/decisions-14-assessing-capacity-video-explanation/

Decisions 12: After assessment

If you are the decision-maker (the person delivering the care or treatment) then it has been up to you to assess the individual's mental capacity to consent to the task you propose. This is true whatever your job title or job description from support worker to clinical psychologist. If you decide that the person lacks the mental capacity to make this particular decision at this particular time then it is up to you to decide what care or treatment to offer in his or her best interests.

It is no easy task to decide what is in the best interests of a person who may lack capacity. Although guidelines have existed in the past the decision has traditionally been based upon clinical judgement and professional opinion with very little hard criteria.

The Mental Capacity Act provides decision-makers with a checklist of things to help them to reach the right decision in the best interests of the person who uses services (principle 4).

"The particular factors in the checklist can be broadly summarized as follows:

Equal consideration and non-discrimination;
Considering all relevant circumstances;
Regaining capacity;
Permitting and encouraging participation;
Special consideration for life-sustaining treatment;
The person's wishes and feelings, beliefs and values;
The views of other people.

It is important to remember that the checklist does not define best interests nor give an exhaustive list of factors to be taken into account. Rather it refers to factors that must always be considered in determining what is in a person's best interests. Not all the factors in the checklist will be relevant to all types of desires or actions, but they must still be considered if only to be disregarded as irrelevant to that particular situation."

Mental Capacity Act 2005
Code of Practice

Section 4 of The Act itself is rather more detailed:

(1)"In determining for the purposes of this Act what is in a person's best interests, the person making the determination must not make it merely on the basis of-

(a) the person's age or appearance, or
(b) a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about what might be in his best interests.

(2)The person making the determination must consider all the relevant circumstances and, in particular, take the following steps.

(3)He must consider-
(a)whether it is likely that the person will at some time have capacity in relation to the matter in question, and
(b)if it appears likely that he will, when that is likely to be.

(4)He must, so far as reasonably practicable, permit and encourage the person to participate, or to improve his ability to participate, as fully as possible in any act done for him and any decision affecting him.

(5)Where the determination relates to life-sustaining treatment he must not, in considering whether the treatment is in the best interests of the person concerned, be motivated by a desire to bring about his death.

(6) He must consider, so far as is reasonably ascertainable-

(a) the person's past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity),
(b) the beliefs and values that would be likely to influence his decision if he had capacity, and
(c) the other factors that he would be likely to consider if he were able to do so.

(7) He must take into account, if it is practicable and appropriate to consult them, the views of-

(a) anyone named by the person as someone to be consulted on the matter in question or on matters of that kind,
(b) anyone engaged in caring for the person or interested in his welfare,
(c) any donee of a lasting power of attorney granted by the person, and
(d) any deputy appointed for the person by the court,
as to what would be in the person's best interests and, in particular, as to the matters mentioned in subsection (6).

(8) The duties imposed by subsections (1) to (7) also apply in relation to the exercise of any powers which-
(a) are exercisable under a lasting power of attorney, or
(b) are exercisable by a person under this Act where he reasonably believes that another person lacks capacity.

(9) In the case of an act done, or a decision made, by a person other than the court, there is sufficient compliance with this section if (having complied with the requirements of subsections (1) to (7)) he reasonably believes that what he does or decides is in the best interests of the person concerned.

(10) "Life-sustaining treatment" means treatment which in the view of a person providing health care for the person concerned is necessary to sustain life.

(11) "Relevant circumstances" are those-
(a) of which the person making the determination is aware, and
(b) which it would be reasonable to regard as relevant."

Mental Capacity Act 2005

Family and friends will not always agree about what is in the best interests of an individual. If you are the decision-maker you will need to clearly demonstrate in your record keeping that you have made a decision based on all available evidence and taken into account all the conflicting views. If there is a dispute, the following things might assist you in determining what is in the person's best interests:

Involve an advocate who is independent of all the parties involved;
Get a second opinion;
Hold a formal or informal case conference;
Go to mediation;
An application could be made to the Court of Protection for a ruling.

Decisions 13: Be reasonable

One common objection when I go through the assessment of capacity and best interests processes with trainees is the possibility that other people might disagree. Typically the concern is that if they make a decision that is challenged or that turns out later to be wrong will the worker or professional be liable to prosecution after the fact?

The best way to explain this is to make several linked points. I'll go through them one by one but first let me just list them:

1. There is only one decision-maker – the person delivering the care or treatment;
2. You don't have to be right – you have to be reasonable;
3. You are expected to do only what is reasonably practicable;
4. You will be judged upon process, not upon outcome.

There is only one decision-maker – the person delivering the care or treatment.

Disagreements happen in every aspect of life, let alone just care provision. They are inevitable. However disagreement is different from being over-ruled.

The burglar might disagree with the policeman's decision to arrest him but that doesn't mean he can prevent it from happening. A bystander might disagree with the paramedic's decision to treat victim A instead of victim B at a road accident but that doesn't mean she can influence the professional's decision. Another professional or worker might disagree with your decision but that doesn't mean that they can stop you from doing what you believe to be right.

You are the decision-maker because you are delivering the care or treatment and although you have to consider the opinions of others you still have the right to do what you believe to be appropriate in the circumstances. This is why there can only ever be one decision maker (team decisions are actually just a group of people making decisions about their own care delivery that compliment each other).

You don't have to be right – you have to be reasonable.

'That's all very well but what if I'm wrong?' is a fairly frequent response

'What if I make a mistake?

Will I be prosecuted then?'

The law doesn't expect us to be right all the time – it expects us to be reasonable in our thinking. We're allowed to make mistakes – in fact that's unavoidable. What we're not allowed to do is ignore what we reasonably could be expected to consider.

There's a very topical illustration of this involving Dewsbury social services.

In February 2008 Karen Matthews reported the disappearance of her daughter, Shannon from her home town of Dewsbury, West Yorkshire. In reality the little girl's disappearance had been orchestrated by Matthews and Michael Doherty, in an attempt to elicit public sympathy and gain donated money by deception. Shannon, who was aged 9 at the time was kept confined (on a leash) throughout. Both were jailed for their offences in December 2008.

Shannon was known to social workers employed by Kirklees Council and so there was a serious case review to establish why this appalling abuse was not prevented.

This week in July 2010 the finding was revealed. There was nothing to suggest that Matthews would perpetrate this elaborate fraud and no way that the social workers concerned could reasonably have been expected to foresee it. They, and you, will not be judged upon whether or not they're right but upon whether or not they could reasonable have been expected to know what was about to happen.

In terms of capacity assessment you are not expected to get it right every time – that would also be impossible. The Mental Capacity Act expects us all to take reasonable steps to ascertain the truth of another person's capacity.

The Mental Capacity Act code of practice makes this point very clearly. Nobody is expected to be telepathic but we are expected to be reasonable in our decisions.

You are expected to do only what is reasonably practicable.

Having concluded that the person lacks the capacity to make a decision you are again expected to be reasonable in your subsequent actions. It may be, for example that you genuinely cannot achieve absolutely the best interests outcome for the individual. It may be, for example that it would be in Mr. Johnston's best interests for him to fly to Australia to be with his dying sister. However you may be in no position to help him with that.

A reasonably practicable intervention might be to assist him in setting up an internet video link or maybe helping him to get in touch with a charity that would help. The law does not ask us to solve all the problems of the world but it does, very definitely ask us to do the best with what we've got.

If you find yourself being criticised for your decision or actions these are the principles upon which you will be judged – not the fact that someone else disagrees. That's inevitable.

You will be judged upon process – not upon outcome.

Over the course of my career I have assessed countless people for suicidal ideation. Like many mental health professionals I've studied the topic extensively and have regularly been asked to make these assessments in a variety of settings.

There is one assessment I will never forget. It was a joint assessment made by me along with a consultant psychiatrist and a junior doctor. We all shared the information that we had and we all agreed that based upon what we saw and the person's previous history there was no reason to believe that this was anything more than an attempt to escape another problem in that individual's life. It's not necessary to elaborate upon what that other problem was. The point is that people often report suicidal intent to escape other consequences and this individual had done the same on a regular basis for many years.

One of the least understood aspects of inpatient mental health care is that we have to spend a lot of time differentiating between the genuinely suicidal individuals and those who have a hidden agenda. We can't accommodate them all – there just aren't the beds.

We all agreed and so we discharged this person from hospital. Two days later he was dead. We had very definitely got it wrong.

There was, of course, an investigation into what had gone wrong and it wasn't pretty. I can assure you that there was no whitewash and there was no cover up. The investigation was thorough and, from my perspective as a professional nurse, extremely frightening.

Fortunately though we were judged upon the process of our decision making and not upon the outcome. If we had been judged upon the outcome, which was tragic, we'd all have been struck off or worse. But the law accepts that we're not clairvoyant and that in the circumstances we found ourselves in all we can do is our best – what's reasonable.

Our decision-making process had been thorough and had taken account of all the significant factors from past history to current presentation and wider life circumstances. We'd consulted with other staff both on the ward and in the community and we had taken into consideration the result of an extensive assessment that had been completed on the ward over the previous three days. We would also have consulted with informal carers had there been any.

The conclusion was that our process had been reasonable. It doesn't change the fact that we have to live with what happened and I for one have never forgotten it but at least the law didn't have a go at us as well.

We're allowed to be fallible so long as our process is reasonable and so are you.

Decisions 14: Advance decisions (AD)

An Advance Decision (AD) allows people to express their views clearly and to make treatment decisions for themselves before they lose mental capacity.

Advance decisions, which used to be called 'advance directives' or 'living wills' could previously be made under common law but the Mental Capacity Act puts them on a statutory footing. It also explains what is required in law for an advance decision to be valid and applicable and introduces new safeguards.

This is important because in the past many care providers have ignored the wishes of those they were providing services to simply because they disagree with them or when faced with someone who lacks capacity to decide they come up with solutions that meets the needs of the carers or the workers without considering the wishes of the service-user.

An advance decision is where a person **aged 18 or over** may set out what particular types of treatment they would not want to have and in what circumstances, should they lack the capacity to refuse consent to this treatment for themselves in the future. It can be about any treatment even if the refusal may result in the person's death and if it is valid and applicable it must be followed. An advance decision does not need to be in writing, except for decisions relating to life-sustaining treatment but it is helpful if it is.

If a person has made an advance decision refusing a particular medical treatment, and that advance decision is valid and applicable, then the refusal has the same force as when a person with capacity refuses treatment.

The MCA introduces a number of rules people must follow when making an advance decision. **If you are making a decision about treatment for someone who is unable to consent to it, you must be satisfied that the advance decision exists, is valid and applicable to the particular treatment in question**. The following list gives a brief summary of some of the main requirements for advance decisions:

It must be valid. The person must not have withdrawn it, or overridden it by making an LPA that relates to the treatment in the advance decision or acted in a way that is clearly inconsistent with the advance decision;

It must be applicable to the treatment in question. It should refer to the treatment in question and the particular circumstances it refers to;

where people are detained under the Mental Health Act 1983 and can therefore be treated for mental disorder without their consent, they can also be given such treatment **despite having an advance decision** to refuse the treatment;

people cannot make an advance decision to ask for medical treatment – they can only say what types of treatment they would refuse;

people cannot make an advance decision to ask for their life to be ended.

If you are satisfied that the decision is valid and applicable then you will have to abide by that decision. The MCA sets out additional formalities for advance decisions that refuse life-sustaining treatment. **An advance decision to refuse life-sustaining treatment must fulfil the following additional requirements:**

It must be in writing, which includes being written on the person's behalf or recorded in their medical notes;

It must be signed by the maker in the presence of a witness who must also sign the document. It can also be signed on the maker's behalf at their direction if they are unable to sign it for themselves.

It must be verified by a specific statement made by the maker, either included in the document or a separate statement, that says that the advance decision is to apply to the specified treatment even if life is at risk. If there is a separate statement **this must also be signed and witnessed**.

An Advance Decision is not an Advance Agreement. People making Advance Decisions do not need workers to agree – they need them to comply.

Consider the following illustration and see if you can answer the questions that follow:

On October 25th 2007 22 year old EG gave birth to twins at the Royal Shrewsbury Hospital. A few hours later she was dead because she refused to accept a blood transfusion. EG was a devout Jehovah's witness. She suffered a sudden haemorrhage and bled to death following a natural delivery. EG had already signed a form before the birth refusing blood in such an event.

According to newspaper reports staff at the hospital tried to get EG's husband and wider family to consent to the blood transfusion on her behalf but they would not.

- Is this 'valid and applicable' as an advance decision to refuse treatment?
- What about the notion that 'decision-makers should not be motivated by a desire to bring about the person's death'?
- What do you make of the staff asking EG's family to overrule her decision?
- If the family had consented would the transfusion have been legal?
- If not – would the family have been liable or the staff who gave it?
- Who was the legal decision-maker in this situation?

Decisions 15: Advance decisions (AD) – answers

Previously I posed a number of questions relating to the case of EG. How did you do?

- Is this 'valid and applicable' as an advance decision to refuse treatment?

Yes it is – although it's not clear from the description I presented you with the form did tick all the right boxes, it had been signed and witnessed and EG did have mental capacity to decide at the time.

- What about the notion that 'decision-makers should not be motivated by a desire to bring about the person's death'?

EG was not motivated by a desire to die – simply by a desire to keep faith with her God. Article 9 of the European Convention on Human Rights discusses the right to freedom of religious expression. All adults have the right to follow their religious views even to their death if they believe it necessary so long as they do not inflict disproportionate damage upon others in the process.

The grief of EG's family does not outweigh the damnation that she would have anticipated had she accepted the blood. It's a proportionate decision motivated not by a desire to die but a desire to follow the requirements of her religious beliefs.

It matters not that the staff present may have disagreed with her religious views. It was her opinion that mattered because it was her life (and her salvation) that was under consideration.

- What do you make of the staff asking EG's family to overrule her decision?

This was at best pointless since the family had no right to overturn EG's decision anyway. There is no automatic right to decide another adult's fate simply because you happen to share a few genes with them or because of a marriage licence. EG had decided for herself.

There is a slight caveat here regarding the Lasting Power of Attorney which we shall discuss later but that wasn't relevant in this case.

- If the family had consented would the transfusion have been legal?

Absolutely not. The family cannot consent to this because it is not their right. So a blood transfusion against the clear refusal of blood laid out in the Advance Decision would have been assault and also 'wilful neglect' under the Mental Capacity Act's new offence.

- If not – would the family have been liable or the staff who gave it?

The staff who delivered the treatment would have been liable. They have the duty of care and so they are responsible and accountable for their actions. Family members telling them to give blood would not be deciding – they would merely be expressing an opinion.

- Who was the legal decision-maker in this situation?

EG. Although at some point she would have lost consciousness and then be said to lack capacity under the MCA she had already made a capacitous decision through her Advance Decision to refuse a blood transfusion.

Decisions 16: Lasting Power of Attorney (LPA)

The MCA introduced a new form of power of attorney, which allows people **over the age of 18** to appoint someone to look after their health, welfare and/or financial decisions, if at some time in the future they lack the capacity to make these decisions for themselves. Bear in mind that although the Mental Capacity Act (2005) is concerned with people aged 16 and over people less than 18 years old cannot appoint someone to hold lasting power of attorney on their behalf. Neither can anyone else do so (acting in their best interests) until the individual is at least 18 years of age.

This does not affect the pre-existing systems for decision-making on behalf of people below the age of 18. Those provisions are as they were.

The person making an LPA is called the donor and the person appointed is known as the attorney. The LPA gives the attorney authority to make decisions on behalf of the donor and imposes upon them a duty to act or make decisions in the best interests (principle 4) of the donor.

For those who still believe that relatives have the automatic right to decide upon people's care and treatment I'd like to pose a question. Why would anyone bother to accept a legal duty of care (with criminal penalties and imprisonment if they neglect it), complete an 24 or 26 page form, get it registered with the government and pay £150 for the privilege if they already had that authority?

The answer, of course is that they wouldn't – but without the registered form they do not have the authority to make decisions for another person – no matter how closely related they are.

There are two different types of LPA:

1 A personal welfare LPA is for decisions about both health and personal welfare (a new kind of power of attorney altogether);

2 A property and affairs LPA is for decisions about financial matters (replaces the old 'enduring power of attorney').

Important facts about LPAs

The introduction of the LPA for property and affairs means that no more Enduring Powers of Attorney (EPA) can be made but the MCA made transitional provisions for existing EPAs to continue. This means that **pre-existing EPAs can continue to be used**.

When a person makes an LPA **they must have the capacity to understand** the importance of the document and the power they are giving to another person.

Before an LPA can be used it must be registered with the Office of the Public Guardian. This is vital. **Without registration an LPA cannot be used at all**.

An LPA for property and affairs **can be used when the donor still has capacity unless the donor specifies otherwise**.

A personal welfare attorney will have no power to consent to, or refuse treatment, at any time or about any matter **when the person has the capacity to make the decision for himself or herself.**

If the person who lacks capacity has created a personal welfare LPA, the attorney will be the decision-maker on matters relating to the person's care and treatment. Unless the LPA specifies limits to the attorney's authority the attorney will have the authority to make personal welfare decisions and refuse treatment (**except life-sustaining treatment**) on the donor's behalf.

Do not be confused about this though:

The attorney can consent to or refuse whatever treatment you might want to offer but they have absolutely no power to demand that you perform any treatment or activity that you would not normally offer.

The decision about appropriate treatments to offer remains with the person delivering the care or treatment. The attorney decides whether to consent, not what treatment to offer.

The attorney must make these decisions in the best interests of the person lacking capacity (principle 4) and if there is a dispute that cannot be resolved, e.g. between the attorney and a doctor, it may have to be referred to the Court of Protection.

If the decision is about life-sustaining treatment, the attorney will only have the authority to make the decision if the LPA specifies this.

Anyone directly involved in the care or treatment of a person should not agree to act as their attorney other than in exceptional circumstances.

Read the LPA to understand the extent of the attorney's power.

A short note about relatives

It has been common practice for many years to ask relatives what to do when service-users lack the capacity to decide for themselves. This has led to a number of difficulties when relatives disagree, either between themselves or with the service-user.

Sometimes relatives can be extremely forceful in trying to tell care workers what they must do and can become angry or abusive if they don't get their own way. Sometimes they will threaten legal action which can be extremely intimidating for staff members trying to go about their business in the best interests of their service-users.

Bear in mind that the relatives are not the decision-makers unless they have a valid and applicable Lasting Power of Attorney.

According to the Mental Capacity Act 2005 the decision-maker is the person delivering the care or treatment unless there is a valid and applicable Lasting Power of Attorney or Advance Decision. This means that in most cases, if you're the person giving the care, you will be the person deciding what care to give.

Even if there is a valid and applicable Lasting Power of Attorney or Advance Decision this does not give people the right to tell you what you must do – only to tell you what you must not do. So people can refuse treatment but they cannot force you to do anything that you think is inappropriate.

Bear in mind that if the treatment you deliver is inappropriate it will be you standing in front of the judge or the coroner.

Also remember that if someone tells you that they hold Lasting Power of Attorney then they are responsible for showing you the LPA document. It is not your job to go looking for a piece of paper that may not exist.

If the relative or friend does hold a valid and applicable Lasting Power of Attorney then they are bound by the Mental Capacity Act's Code of Practice just as you are. This means that they must act in the service-user's best interests at all times. If you reasonably believe that they are not acting in best interests you can challenge them and, if necessary, apply to the Court of Protection for a ruling.

If you believe that the Attorney is actually abusing the service-user then follow the usual Adult Protection procedures.

Decisions 17: IMCA

Early in this series of posts I mentioned the famous Bournewood case in the European Court of Human Rights (HL vs UK 2004).

http://stuartsorensen.wordpress.com/2010/05/24/decisions-2-background/

One of the most significant problems in the Bournewood case related to the lack of representation. When the hospital authorities excluded HL's carers (itself a problem under article 8 ECHR) they also removed any chance that someone would be available to speak on his behalf. In effect they removed all possibility of meaningful advocacy. In an attempt to ensure that this situation does not arise again (at least in relation to the more important decisions made in health & social care) the Mental Capacity Act created the IMCA service.

IMCA stands for Independent Mental Capacity Advocate. INCAs are state appointed (and state funded) advocates who are provided for people who lack capacity to make their own decisions in much the same way that solicitors are provided by the state for people accused of crimes. It's to ensure fair representation.

However the IMCA service does not work with everybody. There are certain criteria to fulfil before a person becomes eligible for the assistance of an IMCA. They must:

Lack capacity to decide;
Have no appropriate advocate of their own.

In addition the decision to be made must be a 'serious'. This means:

Admission to hospital for four weeks or more;
Permanent or long-term change of address;
Serious medical decision;
Safeguarding issue;
DoLS issue.

Let's look at these in turn……

The person must lack the capacity to decide.

The process of assessing mental capacity has already been described:

http://stuartsorensen.wordpress.com/2010/06/14/decisions-10-here-and-now/

http://stuartsorensen.wordpress.com/2010/06/14/decisions-11-the-assessment/

I won't go over the assessment process again here except to remind readers that the assessment must be about the person's ability to make this decision (or type of decision) at this time and not a 'global' assessment.

Only if an individual lacks the mental capacity to decide can an Imca be involved because otherwise they will make their own decision, as is their right.

Have no appropriate advocate of their own

In the Bournewood case the issue was not that there wad nobody to speak for HL but that they were deemed to be inappropriate by the hospital authorities and excluded. So the MCA insists that they be included (see the entry on best interests).

http://stuartsorensen.wordpress.com/2010/06/18/decisions-12-after-assessment/

If there is nobody to speak for the person (or if they are inappropriate because of safeguarding rules then the person will be eligible for IMCA support so long as the decision itself is sufficiently serious.

Sufficiently serious decisions include….

Admission to hospital for four weeks or more. This is also a direct result of the Bournewood case. HL was kept in Bournewood hospital for several months (without effective representation for much of that time). So the Mental Capacity Act stipulates four weeks as the limit of reasonable hospitalisation without effective representation. This doesn't mean that the hospitalisation that lasts less than this time will not need to be justified. It simply means that beyond the four week limit the extra safeguards kick in.

Permanent or long-term change of address

This is defined as eight weeks or more. It is of particular relevance in situations where people enter residential care or are moved from one property to another by social care providers.

Serious medical decisions are defined as interventions that:

Are invasive:
Are traumatic;
Have long-term consequences.

There is no list of procedures that would be covered by this criteria. That would be impossible to codify and to keep updated. Interventions are simply assessed against the above conditions. If they meet any one of the three then the IMCA service may want to be involved.

Safeguarding issues are also within the remit of the IMCA service, particularly when the individual claiming to advocate for the incapacitous person is suspected of abuse.

Deprivation of Liberty Safeguards (DoLS) issues will be covered in more detail later. For now it's enough to say that decisions around DoLS are automatically defined in law as 'serious medical issues' whether or not medical procedures are involved. This is to ensure they meet the criteria for the IMCA service.

If you are the decision maker and the situation meets the criteria then it will be your responsibility to contact the local IMCA service. If you don't do this you commit a criminal offence.

Sometimes people are unsure whether or not to contact the IMCA. If in doubt call and ask. It's better that the IMCA refuse to get involved than that they ask later why you didn't contact them in the first place.

What the IMCA will do….

IMCAs have a particular agenda. They need to be satisfied that the decision maker believes that they are acting in the best interests of the service-user.

They are not going to tell you what to do – that's not their job. The decision still belongs to the person delivering the care or treatment. Technically the IMCA isn't even allowed to have an opinion about what you should do if you're decision maker – only about your good faith.

To decide this they will interview everyone concerned (in private if they wish) and they will also have the right to review and even photocopy and remove relevant documents. This is not a breach of confidentiality because confidentiality is 'need to know', not 'secrecy' and the IMCA needs to know.

The IMCA also has the right under the MCA to reasonable co-operation from care providers and so workers who refuse to co-operate could be prosecuted.

So long as the IMCA believes that you have acted in good faith they will close the case and walk away. However if they are not convinced of that they may well take matters further and could involve the public guardian, the MCA Court of Protection or even the local Adult Protection Committee.

So the basic idea is that the IMCA is an advocate designed to ensure best interests are served. This is hopefully what all care workers want and so they're a helpful asset, not least because they do a lot of legwork to ascertain best interests and then share the information they gain with the decision maker. They are part of the team and they are extremely useful in gathering information.

However, unlike some other advocates in health and social care the IMCA has an official capacity, the right of access to information and a legal process supporting them.

Decisions 18:

Deprivation of Liberty Safeguards (DoLS) – an introduction

The difference between 'restriction' and 'deprivation' of liberty

This isn't the easiest distinction to make. In fact at the time of writing the official guidelines aren't terribly clear at all. This is because the government says that it's waiting for case law to fill in the fine detail about what is and is not deprivation of liberty.

This sounds reasonable enough at first but it's important to be clear. In practice case law involves 'test cases' – these are court cases in which precedents are set. They are also court cases in which people can be found guilty for doing something that wasn't clearly defined as unlawful before they went to court.

Lawyers sometimes call this process 'dog's law' – based upon the way that dogs are (or at least used to be) trained. If you want to train a puppy not to sit on the sofa you don't politely ask it not to – it wouldn't understand. Instead you wait until it does jump on the sofa and then you punish it. The dog is punished for doing something it didn't know was wrong in the first place. This is the essence of dog's law.

The way to avoid falling foul of dog's law is to follow the 'process proscribed by law' – use the DoLS system. That way – if there is a problem it will be with the UK government for creating a system that may be flawed and not with you.

Remember that you can never be prosecuted for ***not*** breaking the law.

This is a very important issue, and is not easy to define clearly and unambiguously.

Restriction of liberty is lawful, as long as what is done is reasonable and proportionate in the circumstances.

For example, you accompany an elderly man who has dementia to the shop. He has limited awareness of the dangers posed by traffic. So when he wants to cross the road, you warn him of the danger, perhaps you hold his arm or his hand gently. If his road sense is especially poor you may try to have two members of staff accompanying him.

Deprivation of liberty, on the other hand, is unlawful without authorisation.

To take the situation above, if you were to prevent this gentleman from ever leaving the building, or if you were to handcuff him to yourself when he does go out, then that would probably constitute a deprivation of liberty. From April 1st 2009 you would need a DoL authorisation in order to carry out such actions lawfully.

It aint what you do – it's the way that you do it!

What constitutes a deprivation of liberty?

“Deprivation is likely to occur when:

Restraint is used (including sedation) to admit a person to an institution where that person is resisting admission;

Staff exercise complete and effective control over the care and movement of a person for a significant period;

Staff exercise control over assessments, treatment, contacts and residence;

A decision has been taken by the institution that the person will not be released into the care of others, or permitted to live elsewhere, unless the staff in the institution consider it appropriate;

A request by carers for a person to be discharged into their care is refused;

The person is unable to maintain social contacts because of restrictions placed on their access to other people;

The person loses autonomy because they are under continuous supervision and Control.”

(Deprivation of Liberty Safeguards Code of Practice)

The Safeguards apply to people who are in a hospital or a care home and who are NOT subject to such other laws.

The new system does not authorise the imprisonment of people in their own homes and it does not allow anyone to deprive people of reasonable choices in any setting other than a hospital or a care home without gaining some other form of legal authorisation.

The Deprivation of Liberty Safeguards (DoLS) process complies with the ‘Winterwerp’ principles from the European Court of Human Rights and is there to ensure that there is a genuine impairment of mind and not merely a disagreement about appropriate care provision.

The easiest way to make sense of this is to refer back to the first stage of the mental capacity assessment (the diagnostic test) which essentially asks if there is an impairment of the mind OR BRAIN.

If a man drinks 12 pints of lager there is a good chance that the functioning of his *brain* will be impaired – he’ll be drunk. This is sufficient grounds to ***restrict*** his liberty and remove his car keys. However it would be illegal to keep hold of his car keys after he sobered up. So ***impairment in the functioning of brain*** alone is only sufficient to allow a restriction of liberty. The same is true for short-term conditions such as toxic confusion resulting from infection.

For ***deprivation*** of liberty it is necessary to show an impairment of ***mind***. This is ‘heavier’ and most probably longer lasting than an impairment of brain alone. Some conditions such as Alzheimer’s dementia will incorporate impairments of both mind ***and*** brain but for DoLS it is the presence of an ***impairment in the functioning of mind*** that is relevant. The Winterwerp conditions are that before an adult can be deprived of their liberty ***in their own best interests***:

1. they must have an impairment of mind;
2. that impairment must be sufficiently serious to cause significant difficulty and;
3. it must present a current problem at the time of the assessment.

Mr. Justice Munby in *GJ v Salford (2007)* said:

"our domestic law must give effect to the principle that an individual cannot be deprived of his liberty on the basis of unsoundness of mind unless three minimum conditions are satisfied: he must reliably be shown to be of unsound mind; the mental disorder must be of a kind or degree warranting compulsory confinement; and the validity of continued confinement depends upon the persistence of such a disorder."

legal precedents

The Mental Capacity Act was introduced in stages. The bulk of the Act was granted royal assent in 2005 and came into effect during 2007. However – there was a problem. The Act was produced in a relatively short time and part of it 'missed the boat' in terms of the legislative or parliamentary timetable. The rules around depriving people of liberty weren't ready. So the original Act only covered the restriction of people's liberty – it was still necessary to apply to the court in order to get authorisation to actually deprive people of their liberty under the Mental Capacity Act.

Then, in 2007 the Mental Health Act received royal assent and along with it came the last part of the Mental Capacity Act to take effect – the deprivation of Liberty safeguards or DoLS for short. This is a new legal framework that allows hospitals or care homes to actually deprive people of liberty legally without going through court procedures.

Bear in mind that this is NOT an extra way for care homes or hospitals to fall foul of the law – it's a way to help them to stay within existing law.

It is still illegal for people to be deprived of their liberty in other settings without going to court.

The Deprivation of Liberty Safeguards are founded in European law around liberty (notably article 5) and reflect a number of European judgements relating to the process and the justifications necessary before a person might be deprived of their liberty.

The DoLS process mirrors the provisions for detention under the Mental Health Act, particularly in terms of emergency versus long-term holding powers and the need for ratification, representation and appeals processes. For readers who are already familiar with the Mental Health Act the table below might be a useful way to compare the two. For those who are not familiar with the Mental Health Act it may still be useful as an overview of the origins and purpose of the new DoLS processes.

DoLS table

Purpose	MCA/DoLS	MHA	Purpose	Legal principles & precedents
Emergency holding	Urgent Authorisation (up to 7 days)	Sections 4, 5(2), 5(4), (up to 72 hours)	To 'hold the individual until proper (prompt) assessment of need can be performed.	Reflects common law doctrine of necessity and Part 5 of the MCA (protection from liability)
Assessment	Best Interests Assessor and Mental Health Assessor	AMHP, RC and Sec 12 Approved Dr.	To ensure need for detention, treatment or care is balanced against the right to liberty.	Article 5(4) ECHR Winterwerp principles
Deprivation of liberty	Standard authorisation (up to 1 year – renewable indefinitely)	Sec 2 (28 days) Sec 3 (6 months leading to 1 year – renewable indefinitely)	To deliver care or treatment as necessary and to further assess where necessary.	Winterwerp Bournewood GJ v Salford 2007
Representation	IMCA 'Relevant Person's Representative'	IMHA, 'Nearest Relative', AMHP	To ensure representation and rights	Article 5(4) ECHR Bournewood
Court access	Court of Protection	MHA Commission	Appeals process	Article 5(4) ECHR

Decisions 19: Josef Fritzl, social care in UK and unlawful deprivation of liberty

In April 2008 the whole world learned about a terrible crime committed by an Austrian father against his own daughter. Twenty four years earlier Josef Fritzl had kidnapped and falsely imprisoned his daughter, Elisabeth in the cellar of his home in Amstetten, Austria. She remained there, repeatedly raped by her father and enduring multiple pregnancies and births for almost a quarter of a century.

Three of her children were to share her imprisonment and one died soon after birth because Fritzl refused to seek help when the child developed breathing problems.

Not surprisingly Josef Fritzl was sentenced to life imprisonment for his crimes.

There were several elements to Fritzl's offences but I want to concentrate upon only one in this post. It may not be the most dramatic when compared to multiple rape and sexual slavery but it is the most relevant. I want to talk about deprivation of liberty.

False imprisonment is an offence in every European state and many other jurisdictions besides. Here in UK we refer back to the European Convention on Human Rights, a set of legal principles that can be traced back to the Treaty of Rome. The earlier treaty was a direct response to the atrocities committed by the Nazis in World War II. The convention covers principles such as freedom of religious expression and outlaws discrimination (in response to the Nazi death camps of the holocaust). It outlaws slavery and forced labour and it includes principles about the right to life and also to association and family involvement. It also insists that there should be no punishment without law.

Essentially the convention is there to ensure that such atrocities can never again happen in any European state – or at least if they do as happened in the former Yugoslavia in the 1990s there will be penalties. In reality that's often all that the law can do – it can't prevent abuse completely but it can ensure an appropriate response. That's why Josef Fritzl went to prison. The law responded.

Article 5 of the European Convention (ECHR) concerns the right to liberty. The article itself can be quite complicated but there is one principle that is very straightforward to understand.

Individuals have the right to liberty 'by default'. Their liberties can only be removed by legal processes. Elisabeth Fritzl had the right to liberty because there was no legal justification for removing it. That's why her father, Josef went to prison himself. He deprived her of her liberty without legal process.

Like all European citizens she could not lawfully be deprived of liberty without good reason and without legal process.

What does all this have to do with health and social care?

First I'd like to ask you a couple of questions – it's something I ask my students in training about liberty from time to time.

Have you ever moved house?

Having moved house have you ever found yourself imprisoned at your new address?

The chances are that you answered 'yes' to the first question and 'no' to the second. That's because changing address is not an imprisonable offence.

Now let's ask another question….

Is growing older an imprisonable offence?

Clearly the answer to this is 'no' – it's OK to grow old and that in itself is no reason for citizens to lose their right to liberty. If it was then everyone who reached a certain age would find themselves imprisoned by the state.

There are two very important principles that we need to get clear:

1 All citizens have the right to liberty unless the law says otherwise;

2 Your service-users have the same rights as you unless the law says otherwise.

I remember delivering training in a residential care home in the Midlands a little while ago. The registered manager told me that they kept the doors locked and did not allow their residents to go outside. When I asked her why this might be she replied:

"Because they're old."

The difference between her residents and herself was really very simple:

They had changed address (moved to a residential care home);

They had grown old.

Neither of these things are imprisonable offences. In legal terms then she was breaching their right to liberty just as Josef Fritzl had done to his daughter. She had condemned her elderly residents to life imprisonment without any legal justification simply because she thought it would be a good idea.

Not every service-user needs to be deprived of their liberty

We can see then that many service-users have exactly the same legal rights as we workers. But they don't all.

Just because people begin by having the right to liberty doesn't mean that they will always have it. Sometimes we do need to deprive them of liberty in order to keep them safe – in their best interests. That's where the deprivation of liberty safeguards (DoLS) comes in to assist hospitals and care homes in England & Wales only. It's a direct response to the Bournewood case (HL vs UK).

The DoLS process is a surprisingly straightforward way to help us deprive people of their liberty when necessary without breaching article 5 ECHR and without becoming another Josef Fritzl. It meets the European criteria for legal authorisation and lets us do what we need to simply and practically instead of having to get a court order or use the Mental Health Act 2007 which isn't always appropriate.

The next few posts will cover the process in detail and will outline exactly what you need to do to keep on the right side of the law whilst still protecting those vulnerable people who really do need to be prevented from putting themselves at risk. After all – we really do have a duty of care to try to protect the vulnerable – just not everybody.

Before we get into the process itself I'd just like to remind you though of the Mental Capacity Act's basic principles. Keep these in mind as we go through the DoLS process too because DoLS is an amendment to the Mental Capacity Act and the same basic guidelines apply.

Principles of the Mental Capacity Act 2005

1. An assumption of capacity

2. Help people to decide

3. People have the right to make decisions that may appear to be eccentric or unwise

4. Best interests

5. Least restrictive intervention

You can check out more comprehensive explanations of each of the principles by following the relevant posts in this series beginning here:

http://stuartsorensen.wordpress.com/2010/05/26/decisions-3-principles/

Decisions 20: Six DoLS assessments

Earlier in this series we introduced the Deprivation of Liberty Safeguards (DoLS). The DoLS process is based upon 6 assessments that must be carried out before we can deprive a person of their liberty. This is because the 6 assessments (or 6 requirements) are based upon European or Domestic UK law and they tell us whether it is legal to deprive a person of their liberty or not.

This section has many more links than usual. This is because the DoLS process is based upon the wider Mental Capacity Act and so if anything is unclear links are provided for readers to check back and remind themselves of principles we covered earlier.

The six qualifying requirements are:

1 Age;

2 No Refusals;

3 Mental Capacity;

4 Mental Health;

5 Eligibility;

6 Best Interests.

1. The **age** requirement: the person must be over 18 years old. Remember that DolS and the Mental Capacity Act that underpins it are designed to fill a hole in the law. We already have a wealth of legal precedent and legislation around liberty and decision-making for people below the age of 18 (eg Gillick competence) and there is no reason to 'rock the boat' by introducing DoLS to a system that already works well.

2. The **no refusals** requirement: the person has not refused the care or treatment which is being suggested (eg through a valid Advance Decision, or via a Lasting Power of Attorney). If you're unsure what this means in practice go back and have another look at the earlier sections on Advance Decisions and Lasting Power of Attorney here:

http://stuartsorensen.wordpress.com/2010/07/28/decisions-14-advance-decisions/

http://stuartsorensen.wordpress.com/2010/07/28/decisions-15-advance-decisions-answers/

http://stuartsorensen.wordpress.com/2010/07/28/decisions-16-lasting-power-of-attorney-lpa/

Briefly put you can only be granted authorisation to deprive a person of their liberty in relation to a specific act or activity. So for example if you want to stop someone from refusing a particular treatment (eg an amputation) then that is what your application will be about. If there are any valid and applicable refusals around amputation under the act then you will not be granted authorisation.

3. The **mental capacity** requirement: the person must lack capacity in relation to

the question of whether or not they should be accommodated in the hospital or care home for the purpose of being given the relevant care or treatment. Remember what we've said about the right to self-determination and the right to refuse treatments. A person with the capacity to decide makes their own decision – even if we think they're making a mistake. It's their decision not ours.

To get a sense of how capacity is assessed and what it means in practice look here:

http://stuartsorensen.wordpress.com/2010/06/14/decisions-10-here-and-now/

http://stuartsorensen.wordpress.com/2010/06/14/decisions-11-the-assessment/

You can also view my video explanation here:

http://stuartsorensen.wordpress.com/2010/06/25/decisions-14-assessing-capacity-video-explanation/

4. The **mental health** requirement: the person must be suffering from a mental

disorder within the meaning of the Mental Health Act (and in this case this also

includes a learning disability). This is because there must be an impairment of mind before a person can be deprived of liberty in their best interests (and DoLS is always about that person's best interests – not anyone else's. We have other legislation for deprivation that isn't in the individual's best interests such as the criminal justice system.

The importance of impairment of mind was discussed here:

http://stuartsorensen.wordpress.com/2010/08/16/deprivation-of-liberty-safeguards-dols-an-introduction/

This is extremely important. If you wish to restrict a person's liberty in their best interests you need to show that they have an impairment of mind or brain. An impairment of brain might be toxic confusion resulting from a urinary tract infection and the appropriate restriction (which workers can do without outside authorisation) might be to limit the person's movements for a few days whilst the antibiotics deal with the infection. This would be a **restriction** justified by an impairment of **brain**.

Deprivation of liberty is more serious and cannot be justified by an impairment of brain alone. There must be an impairment of **mind**. This is more serious. It's all about being proportionate and using the least restrictive intervention necessary to get the job done. Remember that the least restrictive intervention is one of the five principles of the Mental Capacity Act:

http://stuartsorensen.wordpress.com/2010/06/06/decisions-8-least-restrictive/

http://stuartsorensen.wordpress.com/2010/05/26/decisions-3-principles/

5. The **eligibility** requirement: the person is not ineligible to have his/her liberty

deprived (eg the person is not currently detained under the Mental Health Act).

This is relatively straightforward. Every decision to deprive a person of their liberty must be covered by legal process and sometimes there will be a potential conflict between one piece of legislation and another. For example if there is an injunction against an individual forbidding them to within two miles of a certain address you will not be able to get DoLS authorisation to place them in a care home in the same street. In this case the person will be said to be ineligible because the law already forbids them from living where you want them to.

6. The **best interests** requirement: it must be decided that depriving the person's liberty will be in that person's best interests. There is a checklist in the Mental Capacity Act that tells us how to determine what is in a person's best interests. The basic principle is that people are individuals and what is right for one person might not be right for another. So, to work out what is in a particular individual's best interests we need to consider the things that make them unique.

You can remind yourself of the best interests checklist by clicking here:

http://stuartsorensen.wordpress.com/2010/06/02/decisions-7-best-interests/

http://stuartsorensen.wordpress.com/2010/06/18/decisions-12-after-assessment/

Decisions 21: The DoLS process itself

In this final post of the 'Decisions' series I'll outline the DoLS process itself as it applies to care homes and hospitals in England & Wales. I hope you've found the series useful. Don't forget that if you'd like a free downloadable copy of the entire series as a single pdf document Email me at stuart.sorensen@googlemail.com and I'll send you a copy. Even better – if you'd like to arrange for me to come and train your staff in this stuff just let me know. Anyway – to business….

There are two types of DoLS authorisation:

- Emergency authorisation;
- Standard authorisation.

It is interesting that the process can be said to mirror the Mental Health Act, particularly in terms of 'emergency' versus 'long-term' holding powers and the need for ratification, representation and appeals processes. We've already seen the table below which provides a very rough outline but I'm reproducing again it here. We'll go through it in a little more detail too.

Similarities between DoLS and the MHA

Purpose	**MCA/DoLS**	**MHA**	**Purpose**	**Legal principles & precedents**
Emergency holding	Urgent Authorisation (up to 7 days)	Section 4, 5(2), Section 4,5(4), (up to 72 hours)	To 'hold the individual until proper (prompt) assessment of need can be performed.	Reflects common law doctrine of necessity and Part 5 of the MCA (protection from liability)
Assessment	Best Interests Assessor and Mental Health Assessor	AMHP, RC and Sec 12 Approved Dr.	To ensure need for detention, treatment or care is balanced against the right to liberty.	Article 5(4) ECHR Winterwerp principles (1979)
Deprivation of liberty	Standard authorisation (up to 1 year – renewable indefinitely)	Sec 2 (28 days) Sec 3 (6 months leading to 1 year – renewable indefinitely)	To deliver care or treatment as necessary and to further assess where necessary.	Winterwerp Bournewood GJ v Salford 2007
Representation	IMCA 'Relevant Person's Representative'	IMHA, 'Nearest Relative', AMHP	To ensure representation and rights	Article 5(4) ECHR Bournewood
Court access	Court of Protection	MHA Commission	Appeals process	Article 5(4) ECHR

As we have discussed already, once we pass the threshold and move from mere ***restriction*** of liberty to actual ***deprivation*** of liberty then the rules about who is the decision maker change. For decisions about restriction of liberty the decision-maker is the person delivering the care or treatment as we have seen. But for decisions around the more serious prospect of deprivation of liberty we need more. At this point it becomes unlawful for the person delivering the care and treatment to authorise deprivation of liberty for more than the short-term (emergency).

At this point decision-making authority passes to the ***'supervisory body'*** in general and specifically to the ***Mental Health Assessor*** and the ***Best Interests Assessor***. Depending upon whether you work in a care home or hospital the supervisory body will be the local authority (LA) or the local primary care trust (PCT). This is because LAs and PCTs are publically funded and can be described as ***'arms of the state'***, and already hold governing authority over health and social care matters.

The care home or hospital itself is known as the ***managing authority***. Think of the day to day task of 'managing' the care and treatment of the individual concerned as a way to remember this. The care home or hospital manages and the local authority or primary care trust supervises that care home or hospital.

Managing authorities need the permission of the supervisory body if they want to deprive a person of their liberty.

If this seems strange to you just imagine what it would be like if someone like Josef Fritzl had been legally able to decide upon deprivation of liberty without seeking outside authorisation. It is not enough simply to trust that individuals will always act appropriately. In fact there is a great deal of evidence from professional 'fitness to practice' hearings to show that a great many people act extremely inappropriately when left to their own devices.

Your service-users may well have the same legal right to liberty as Fritzl's daughter, Elisabeth had. It's not up to us as individual workers to make those decisions for ourselves – instead society as a whole decides via the DoLS process and specially trained assessors.

Emergencies

In an emergency it is not uncommon to deprive a person of their liberty before authorisation can be granted. There just isn't time to get the assessors to make a decision when the person is already heading out to walk under a bus. That's what the emergency authorisation is all about.

This is rather like the 'emergency holding power' that nurses use under the Mental Health Act. It doesn't provide a long term solution but it does let us deprive them of their liberty in the short term while we're waiting for a proper decision from the supervisory body.
In an emergency the managing authority follows their own step by step process:

1 Notice the problem;
2 Decide what to do;
3 Deprive the person of their liberty (or not);
4 Fill in & send off the emergency authorisation form;
5 Fill in and send off the request for standard authorisation.

It is important that the request for standard authorisation is sent off as soon as possible because the assessment takes a little time to arrange and in normal circumstances an emergency authorisation can only last for 7 days. Once the supervisory body has received the request they will arrange for the DoLS assessors to visit.

The assessors

There must be at least two DoLS assessors. Usually this means one Mental Health Assessor (registered as competent under section 12 of the Mental Health Act 1983/2007) and one Best Interests Assessor (BIA). They each have their own specific areas of expertise and the six assessments are divided out between them. Remember that the six assessments or 'requirements' are:

The age requirement;
The no refusals requirement;
The mental capacity requirement;
The mental health requirement;
The eligibility requirement;
The best interests requirement.

The mental health assessor attends to two of these assessments….

The mental health requirement – here the mental health assessor is checking to confirm that there is a genuine impairment of mind in accordance with the Winterwerp principles discussed earlier:

1. ***An impairment of mind;***
2. ***An impairment sufficiently severe to warrant intervention;***
3. ***The impairment is currently causing problems.***

Only if the Winterwerp criteria are met will the mental health assessor allow the assessment process to continue.

The eligibility requirement – here the mental health assessor is checking that there would be no conflict with the mental health act if the deprivation of liberty was to go ahead.

The best interests assessor completes the other four assessments:

The age requirement – the individual must be at least 18 years old as previously discussed;

The no refusals requirement – ensures there are no valid and applicable refusals under the Mental Capacity Act;

The mental capacity requirement – ensures that the relevant person does indeed lack the capacity to decide for themselves;

The best interests requirement – ensures that the proposed deprivation of liberty is genuinely in the relevant person's best interests as outlined earlier in this series of blog posts.

Assuming that all six qualifying requirements are met then the supervisory body MUST grant authorisation to deprive liberty; it has no discretion in this matter.

Time limits and conditions

The authorisation is time limited. The maximum length for which authorisation can be granted is 12 months, but the actual length cannot be longer than that which is recommended by the best interests assessor. So it might be that the assessor will recommend a period of three months after which the authorisation will expire. If the managing authority thinks that deprivation is necessary beyond that time they must apply again for standard authorisation.

The best interests assessor may also recommend conditions to be attached to the DoLS authorisation, such as steps to be taken to keep in touch with family, or to ensure that cultural needs are met.

The 'relevant person's representative'

Assuming that the best interests assessor recommends that authorisation be granted, they will also recommend someone to be the person's "representative". The representative's role is to keep in touch with the person, to support them in all matters relating to the deprivation of liberty, and to request a review or to make an application to the Court of Protection on the person's behalf where necessary.

The representative would normally be a family member or friend, but it does not have to be. It could be an independent person (and that person could be paid) if the best interests assessor feels that would be appropriate.

There is a legal duty on hospital and care home managers to ensure that the person, and his/her representative, understand what the authorisation means and that they can apply for a review at any time.

Renewals and reviews

If there is any change in the person's circumstances then this may require a review to be carried out. The hospital or home manager must notify the supervisory body of any such changes.

The person, or the person's representative, can request a review at any time. They can also appeal to the Court of Protection.

Thankyou

Well that's it – we've reached the end of this introduction to the Mental Capacity Act and the Deprivation of Liberty Safeguards.

I've tried to make it accessible and understandable to people who aren't generally used to thinking about the law in too much detail. In fairness that's been rather unfamiliar territory for me.

I'm very used to making the law accessible to care workers in a face to face setting but this is my first major stab at doing so in written form. I'd be very grateful if you would take the time to let me know how effective this booklet has been. I know that we've covered some pretty 'heavy' issues here.

Please don't hesitate to contact me via the blog or on Twitter (see the header & footer of each page) if you have any comments or criticisms. That's the only way that these Ebooks will improve.

Many thanks.

Stuart Sorensen