MEDICAL PROTECTION SOCIETY
PROFESSIONAL SUPPORT AND EXPERT ADVICE

Mental Capacity Act 2005

Deprivation of Liberty Safeguards (MCA DOLS)

Advice correct as of July 2010

Introduction

The Mental Capacity Act Deprivation of Liberty Safeguards (MCA DOLS) (formerly known as the Bournewood safeguards) were introduced into the Mental Capacity Act 2005 through the Mental Health Act 2007.

MCA DOLS provides legal protection for individuals who lack capacity (for example those with severe autism or dementia) and who may be deprived of their liberty in hospitals or care homes to protect them from harm. These individuals are not covered by the Mental Health Act 1983 safeguards. MCA DOLS came into force in England and Wales on 1 April 2009. This factsheet provides a broad overview of MCA DOLS as it applies to England.

Who does MCA DOLS apply to?

The MCA DOLS apply to anyone:

- Aged 18 and over
- Who suffers from a mental disorder or disability of the mind – such as dementia or a profound learning disability
- Who lacks the capacity to give informed consent to the arrangements made for their care and/or treatment and
- For whom deprivation of liberty (within the meaning of Article 5 of the European Convention on Human Rights) is considered after an independent assessment to be necessary in their best interests to protect them from harm.

MCA DOLS cover patients in hospitals, and people in care homes registered under the Care Standards Act 2000, whether placed under public or private arrangements.

The new system cannot be used to detain people in hospital for treatment of a mental disorder in situations where the Mental Health Act 1983 could instead be used if they are thought to object to detention or treatment.

What is the purpose of MCA DOLS?

The safeguards are designed to protect the interests of an extremely vulnerable group of individuals and to:

- Ensure people can be given the care they need in the least restrictive regimes
- Prevent arbitrary decisions that deprive vulnerable people of their liberty
- Provide them with rights of challenge against unlawful detention
- Avoid unnecessary bureaucracy.

Why are these safeguards necessary?

MCA DOLS address the October 2004 European Court of Human Rights judgment in *HL v the United Kingdom* (the Bournewood judgment). The Bournewood case concerned an autistic man with severe learning disabilities who was informally admitted to Bournewood Hospital. It was held that he was unlawfully deprived of his liberty because of the absence of a legal procedure that provided safeguards against arbitrary detention and speedy access to court.

How does MCA DOLS work?

When a hospital or care home (designated as "managing authorities" under the legislation) identifies that a person who lacks capacity is being, or risks being, deprived of their liberty, they must apply to the "supervisory body" for an authorisation of deprivation of liberty. The "supervisory body" for hospitals is the relevant PCT and for care homes it is the local authority.

Authorisation should be obtained in advance except in urgent circumstances. The supervisory body must obtain six assessments:

- Age assessment
- No refusals assessment
- Mental capacity assessment
- Mental health assessment
- Eligibility assessment
- Best interests assessment.

The assessments must usually be completed in 21 days of the request for the authorisation. "Assessors" appointed by the managing authority will carry out the assessments. "Assessors" will usually be doctors, nurses, social workers, or psychologists depending on the particular type of assessment. Detailed provisions about the selection and appointment of assessors are set out in legislation (see MPS's factsheet on *Assessments under MCA DOLS* for further information).

A representative – either a suitable relative or friend of the person concerned, or alternatively an Independent Mental Capacity Advocate (IMCA) – will be appointed to represent the individual's interests. Legislation provides for the selection and appointment of representatives. (See MPS's factsheet on *Independent Mental Capacity Advocates* for further information).

The duration of an authorisation will be determined on a case-by-case basis but may not be longer than 12 months. The managing authority can apply for a further authorisation when the authorisation expires. The authorisation can be reviewed at any time, and must be reviewed if this is requested by the individual or their representative.

If any of the assessments determine that the individual does not satisfy the criteria for an authorisation, the supervisory body must refuse the request for authorisation.

How many people are affected by MCA DOLS?

The Department of Health published the first statistics on MCA DOLS in June 2010. The figures show that the number of authorisations completed was:

- 1,838 in quarter 4
- 1,772 in quarter 3
- 1,681 in quarter 2
- 1,869 in quarter 1.

Further information

The Deprivation of Liberty Safeguards Code of Practice (August 2008), provides guidance on MCA DOLS
www.dh.gov.uk

The Department of Health website provides a range of comprehensive and helpful information about MCA DOLS
www.dh.gov.uk

The Department of Health has also published the following guides:

A guide for primary care trusts and local authorities (supervisory bodies)

A guide for hospitals and care homes (managing authorities)

A guide for relevant persons' representatives.
www.dh.gov.uk

MPS factsheet, Assessments under MCA DOLS
www.medicalprotection.org/uk/factsheets

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Assessing capacity

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The Mental Capacity Act states that a person lacks capacity if they are unable to make a specific decision, at a specific time, because of an impairment of, or disturbance, in the functioning of mind or brain. This factsheet sets out the things to look for when assessing the capacity of a patient.

Mental capacity

Mental capacity is the ability to make a decision. If a person lacks capacity, they have an impairment or disturbance that leaves them unable to make a decision.

The loss of capacity could be partial or temporary. It is possible for a person to lack capacity to make one specific decision but not about another.

The reasons for questioning if a person has capacity to make a decision at a particular time may be that:

- The person's behaviour or circumstances raise doubt as to whether they have the capacity to make a decision.
- Concerns about a person's capacity have been raised by someone else; for example, a family member or a healthcare worker.
- The person has previously been diagnosed with a condition causing an impairment to the performance of their mind or brain, and it has already been shown that they lack capacity to make other decisions.

Assessing capacity

If you think that an individual lacks capacity, you need to be able to demonstrate it. You should be able to show that it is more likely than not – ie, a balance of probability – that the person lacks the capacity to make a specific decision when they need to.

You should not base the assessment of a person's capacity solely on the person's age, appearance, assumptions about their condition (this is wide-ranging and includes, for example, drunkenness or unconsciousness) or any aspect of their behaviour.

It is important to document any decisions you make in assessing capacity, and any reasons for the clinical judgement that you come to.

Decision-making

Assessing a person's capacity accurately is important; otherwise, a person could end up making decisions that are unwise and not in their best interests, or being denied their right to make a specific decision.

The starting assumption should always be that the person has capacity. The Act details a two-stage test of capacity:

1. **Does the person have an impairment, or a disturbance in the functioning, of their mind or brain?** This can include, for example, conditions associated with mental illness, concussion, or symptoms of drug or alcohol abuse.
2. **Does the impairment or disturbance mean that the person is unable to make a specific decision when they need to?** You should offer appropriate and practical support to achieve this before applying this stage of the test.

Continued over

Functional tests of capacity

To be able to make a decision a person should be able to:

- Understand the decision to be made and the information provided about the decision. The consequences of making a decision must be included in the information given.
- Retain the information – a person should be able to retain the information given for long enough to make the decision. If information can only be retained for short periods of time, it should not automatically be assumed that the person lacks capacity. Notebooks, for example, could be used to record information which may help a person to retain it.
- Use that information in making the decision – a person should be able to weigh up the pros and cons of making the decision.
- Communicate their decision – if a person cannot communicate their decision – for example, if they are in a coma – the Act specifies that they should be treated as if they lack capacity. You should make all efforts to help the person communicate their decision before deciding they cannot.

You will need to assess a person's capacity regularly, particularly when a care plan is being developed or reviewed.

Other points

Capacity is dynamic and a specific function in relation to the decision to be taken. This will need to be regularly assessed in relation to each decision taken, and carefully documented.

Further information

- Mental Capacity Act – www.opsi.gov.uk
- Mental Capacity Act Code of Practice, Chapter 4 – www.justice.gov.uk
- Ministry of Justice – www.justice.gov.uk
- DH – www.dh.gov.uk
- The Office of the Public Guardian – *Making Decisions: A Guide for People who work in Health and Social Care Booklet 3* – Mental Capacity Act 2005 – www.publicguardian.gov.uk

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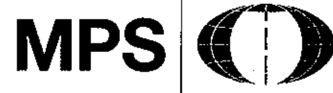
Advance decisions



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An advance decision ("living will") to refuse future medical treatment – should the patient then lack capacity – can be made by a person who is over 18 and who has capacity. This factsheet gives further information about advance decisions.

Advance decision

A valid and applicable advance decision to refuse treatment must be specific to the treatment in question. It has the same force as a contemporaneous decision. As a medical professional, you must follow an advance decision if it is valid and applies to the decision that needs to be made. If you do not follow an advance decision, you could be charged with committing a crime or civil liability.

A valid and applicable advance decision overrules:

- the best interests provision, which would otherwise allow healthcare professionals to give treatment they believe is in the individual's best interests; therefore, **you must follow an advance decision, even if you do not believe it is in the patient's best interests.**
- the decision of any personal welfare Lasting Power of Attorney (LPA), made before the advance decision was made.
- the decision of any court-appointed deputy.

The Court of Protection has no power to overrule a valid and applicable advance decision to refuse treatment.

What should it contain?

An advance decision can only be made by a person with capacity and can only refuse treatment in the future; it cannot demand specific treatments.

The statement should specify precisely what treatment is to be refused, and the circumstances in which the refusal should apply. It will only apply when the person lacks the capacity to consent to, or refuse this treatment. The decision may be either written or verbal. When it is in relation to life-sustaining treatments, it must be written, signed and witnessed. It can be amended or withdrawn at any time.

It is the responsibility of the person making the advance decision to make sure the healthcare professionals treating them are aware of any decision that has been made. It is recommended that the individual informs their family and GP. Some people will carry a card or wear a bracelet to alert you to the fact that they have an advance decision.

Artificial nutrition and hydration (ANH) is a recognised form of medical treatment and, therefore, can be refused in an advance decision. However, as with all refusals for life-sustaining treatment, it must satisfy requirements in the advance directive – written, signed and witnessed.

Determining whether the advance decision is valid and applicable

If you become aware that a patient who currently lacks capacity has previously made an advance decision about their treatment you must make reasonable efforts to find out details of the decision. This might involve discussions with the patient's relatives, looking at the patient's notes or contacting the patient's GP, and determining if there is an LPA.

Continued over

Once you are aware the decision exists, you need to determine if it is **valid** and **applicable**, in which case you must follow it. If you are satisfied that either an advance decision does not exist, or that an existing advance decision is not valid or applicable in this case, the treatment you give must be in the patient's best interests. You should make clear notes in the patient's records about your decision and why the advance decision has not been followed.

Is the advance decision valid?

An advance decision may be invalid if:

- the decision was withdrawn while the person had capacity
- after the advance decision was made, an LPA was appointed and given express authority to make the treatment decisions that were covered by the advance decision
- the person has done something that clearly goes against the advance decision, which suggests that they have changed their mind.

No individual can make an advance decision to ask for their life to be ended – assisted suicide and voluntary euthanasia remain unlawful.

Is the advance decision applicable?

The advance decision must apply to the situation in question. It is not applicable if:

- the patient has capacity
- the treatment is not the treatment specified in the advance decision
- there are reasonable grounds for believing that there have been changes in circumstances which, in hindsight, would have affected the person's decision.

Emergencies

You should not delay emergency treatment to look for an advance decision if you have no indication that one exists. If there is an indication that one exists, you should assess its validity and applicability to the emergency situation as soon as possible and apply it.

Conscientious objection

If you disagree in principle with the patient's right to refuse life-sustaining treatment, you should discuss this with a senior colleague and arrange for the transfer of the management of the patient to a colleague.

Disagreements

It is for you to decide if your patient's advance decision is applicable and valid. When there is a disagreement about the advance decision, you must consider all available evidence, which will often involve consulting with family, close friends of the patient, carers and the LPA. All the staff involved in the patient's care should be consulted and also the patient's GP. Details of these discussions should be recorded in the patient's notes.

If there is still doubt or disagreement, you should refer the decision to the Court of Protection. The Court cannot overturn a valid and applicable advance decision. Whilst the Court comes to a decision, life-sustaining treatment and any treatment required to prevent the patient's condition deteriorating should be provided. There are emergency legal procedures in place that operate 24 hours a day, to deal with urgent cases quickly.

Further information

- MPS Mental Capacity Act factsheets series
- Mental Capacity Act – www.opsi.gov.uk
- Safeguarding Vulnerable Groups Act 2006 – www.opsi.gov.uk
- Mental Capacity Act Code of Practice, Chapter 9 – www.justice.gov.uk
- Ministry of Justice – www.justice.gov.uk
- DH – www.dh.gov.uk
- The Office of the Public Guardian – *Making Decisions: A Guide for People who work in Health and Social Care Booklet 3* – Mental Capacity Act 2005 – www.publicguardian.gov.uk

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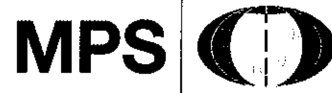
Best interests tests



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The best interests principle The Mental Capacity Act (the Act) 2005 states that any act done or decision made on behalf of an adult lacking capacity must be in their best interests. This can cover financial, health and social care decisions. The person making the decision is the "decision-maker" and is likely to be the person caring for the patient on a day-to-day basis, the doctor or other member of the healthcare staff responsible for carrying out the particular treatment or procedure, or an LPA or Court of Protection deputy.

The best interests test

The Act sets out what you must consider when deciding what is in the best interests of your patient. You should take into account:

- past and present wishes and feelings
- beliefs and values that may have influenced the decision being made, had the person had capacity
- other factors that the patient would be likely to consider if they had capacity.

You must have objective reasons for any decision you make. You must also be able to show that you considered all circumstances relevant to the decision in question.

In trying to assess the best interests of a person lacking capacity, you should:

- **Encourage the person lacking capacity to participate in the decision.**
  To do this, it may be necessary to use specific communication methods; for example, simple language or pictures, or by using a specialist to help communicate.
- **Avoid discrimination.**
  The Act specifically states that decisions cannot be based on a person's age, appearance or condition or any aspect of the person's behaviour. The appearance can refer to all aspects of a person's physical appearance, while the condition can include learning difficulties, age-related illnesses or temporary conditions (such as unconsciousness or drunkenness).
- **Try to identify all the issues most relevant to the person who lacks capacity and to the specific decision to be made.**
  These will vary from case to case, depending on the capacity of your patient and the decision needing to be made.
- **If possible, defer the decision if the patient is likely to regain capacity.**
  In emergency situations, it may not be possible to wait for the patient to regain consciousness.

Life-sustaining decisions

It is a fundamental rule that **decisions regarding life-sustaining treatment must not be motivated by a desire to bring about the person's death**. As the healthcare professional, you must decide whether or not the treatment you are giving is life-sustaining in each particular situation. Before selecting the treatment, you should consider all the options, including the factors in the best interest tests. You should take into account any statements the patient may have previously made, and the views of family and carers.

You are not under an obligation to provide life-sustaining treatment that is not in the best interests of the patient. If there is a dispute about this, contact MPS for advice. The Court of Protection may also be approached to make decisions about what is in the person's best interests.

Continued over

In some cases, the patient may have made an advance decision to refuse life-sustaining treatment – there is further information on this in the MPS factsheet – *Advance Decisions*.

Take into account a person's past and present wishes

The Act specifies that, as far as reasonably ascertainable (considering all possible information in the time available, such as differences between an emergency and a non-emergency situation) the following issues should be considered:

- the person's past and present wishes and feelings – for example, if a person had strongly-held views in the past, this may shape their treatment.
- there might be written statements that provide information about an individual's wishes of how they would like to be cared for. Written statements are different to advance decisions to refuse treatment.
- the beliefs and values that would be likely to influence their decision if they had the capacity – evidence of this can be found by looking at an individual's cultural background, religious beliefs, political and moral convictions or past behaviour or habits.
- other factors that they would be likely to consider if they were able to do so – for example, the effects of such a decision on other people, eg, dependents.

You should also seek the views of the people closest to the individual who lacks capacity, as well as the views of an LPA or Court of Protection appointed deputy.

Whom should you consult?

You have a duty to consult with other people close to the patient. Where appropriate, include those named by the individual when they had capacity. You should also consult any LPA and, where appropriate, the Court of Protection attorney or deputy. If there is no-one to discuss the individual's best interests, the incapacitated individual may qualify for an Independent Mental Capacity Advocate (IMCA). See the MPS factsheet – *Independent Mental Capacity Advocates* for further information.

Duty of confidentiality

You need to balance the duty to consult with other people with the patient's right of confidentiality. In situations where this is unclear you should contact either the Information Commissioner or MPS for further advice.

Records

Keep good records of how and why the decision about the person's best interests was reached, who was consulted, and the factors that you did or did not take into account. This should include witnesses of the individual's capacity to make the decision.

Exceptions to the principle

There are two exceptions to the best interests principle:

- If the patient made an advance decision to refuse certain medical treatment whilst they had capacity and there is no reason to believe they subsequently changed their mind.
- Involvement in research (chapter 11 of the Mental Capacity Act Code of Practice).

Further information

- MPS Mental Capacity Act factsheets series
- Mental Capacity Act – www.opsi.gov.uk
- Safeguarding Vulnerable Groups Act 2006 – www.opsi.gov.uk
- Mental Capacity Act Code of Practice, Chapter 9 – www.justice.gov.uk
- Ministry of Justice – www.justice.gov.uk
- Department of Health – www.dh.gov.uk
- The Office of the Public Guardian – *Making Decisions: A Guide for People who work in Health and Social Care Booklet 3* – Mental Capacity Act 2005 – www.publicguardian.gov.uk

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Independent Mental Capacity Advocates

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The role of Independent Mental Capacity Advocates (IMCAs) is to support and represent a person who lacks capacity in making a specific decision, and who has no-one (other than paid carers) to support them. This factsheet sets out further information about IMCAs and the role they play.

What is an IMCA?

An IMCA is independent of the person making the decision. The IMCA:

- provides support for the person who lacks capacity
- represents the person without capacity in discussions about any proposed treatment
- provides information to work out what is in a person's best interests
- questions or challenges decisions that they believe are not in the best interests of the person lacking capacity
- presents individuals' views and interests to the decision-maker.

The IMCA is not the decision-maker but you have a duty to take into account the information and views expressed by the IMCA.

When will an IMCA be involved?

IMCAs are available to individuals who:

- lack the capacity to make a specific decision about serious medical treatment or long-term accommodation
- have no family or friends available and appropriate to support or represent them
- have not previously named someone who can help with a decision
- have not made an LPA (or, before October 2007, an EPA).

This list is not exhaustive and, if you are unsure whether or not to involve an IMCA, you should contact your responsible body (the NHS organisation arranging and funding the patient's care). Further information can also be provided by Patient Advice and Liaison Service and the Citizens Advice Bureau. The Department of Health website and the Community Councils in Wales also give further information about this.

What decisions can an IMCA be involved in?

There are specific decisions with which an IMCA must be involved. These relate to:

- providing, withholding or stopping serious medical treatment
- moving a person into long-term care in hospital for longer than 28 days or a care home for longer than eight weeks
- moving the person to a different hospital or care home.

NHS bodies can also decide to instruct IMCAs in decisions concerning care reviews or in adult protection cases, where it is thought that someone is or has been abused or neglected by another person, or someone is abusing or has abused another person.

Continued over

What is serious medical treatment?

- 5 OCT 2010

The definition of serious medical treatment includes the treatment of both physical and mental conditions; therefore, you should instruct an IMCA if you are:

- giving new treatment, stopping treatment or withholding treatment, in circumstances where there is a fine balance between the likely benefits, burdens and the risks of the single treatment to the patient
- deciding between treatments where the choice is not clear
- considering treatment which is likely to have serious consequences for the patient.

Serious consequences include where treatment or the decision to treat:

- causes serious and prolonged pain, distress or side-effects
- has potentially major consequences, ie, surgery or life support treatment discontinuation
- has a serious impact on the patient's future life choices.

Emergency situations

In emergency situations, it is likely that you may not have time to instruct an IMCA. You should record any decisions you make about the treatment you give, and the reasons for them, in the patient's notes. If treatment with serious consequence follows from the emergency treatment, then you should instruct an IMCA.

You should always act in the patient's best interests while you are waiting for the IMCA's report.

Disagreements

An IMCA has the right to challenge decisions about the assessment of capacity and about what is in their client's best interests. They may, for example, challenge a decision if they did not feel that enough attention had been paid to their report and any other relevant information.

If the IMCA disagrees with the treatment you have suggested, you should take time to explain and discuss it with them and try to come to an agreement. If an agreement cannot be reached, the IMCA may use the formal complaints system to settle the case or, in more urgent cases, may refer the decision to the Court of Protection.

Further information

- MPS Mental Capacity Act factsheet series
- Mental Capacity Act – www.opsi.gov.uk
- Safeguarding Vulnerable Groups Act 2006 – www.opsi.gov.uk
- Mental Capacity Act Code of Practice, Chapter 10 – www.justice.gov.uk
- Ministry of Justice – www.justice.gov.uk
- DH – www.dh.gov.uk
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