Mental Capacity Workshop

BGS Spring Meeting
Bournemouth 2009

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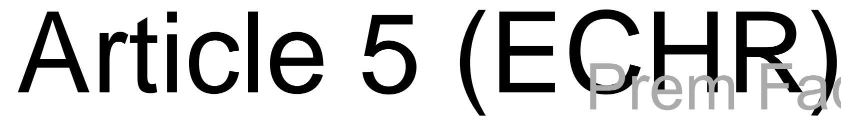
Aims of session

- Deprivation of liberty safeguards
- Applying the Mental Capacity Act – some cases for discussion



Article 5 (ECHR)

- **Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law: ……**

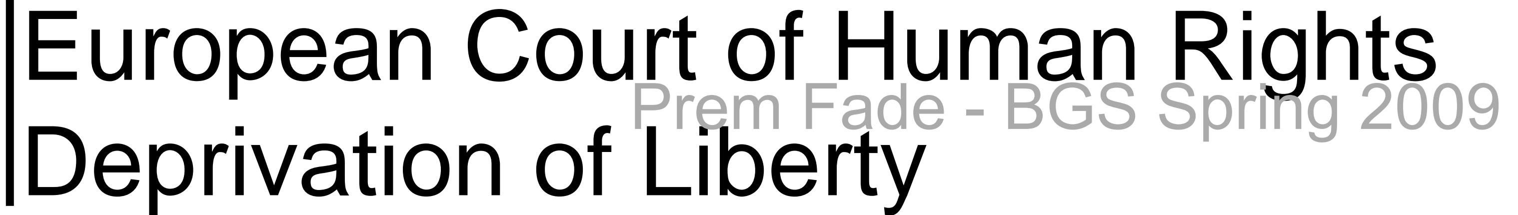
4 Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful.

Background

- HL v United Kingdom 2004
- The Bournewood Case
- HL –autistic man who lacked capacity to make a decision re hospital treatment.
- Admitted informally under common law in his best interests.
- Carers had restricted access to HL and wanted him discharged to their care.
- HL had no means of independent representation or appeal.

The Bournewood Gap

- No legal process to authorise deprivation of liberty
- And no safeguards against arbitrary deprivation of liberty
- No right to independent representation
- No right of appeal



- No definition
- No check list
- Depends on specific circumstances
- Not nature or substance
- Intensity and degree
- Cumulative

More case law

- TG, 78 years old with dementia lives in care home
- Admitted to hospital with pneumonia
- Dispute between family and SS
- TG returned to care home against family’s wishes
- TG was happy in care home, visiting unrestricted.
- Court- restriction not deprivation of liberty.

Another case

- DE, dementia, stroke disease, blind
- Left on pavement by wife JE
- Admitted to care home by social services
- Unrestricted visiting at care home
- DE expresses consistent wish to return home.
- JE also wishes to have DE home
- Court- Deprivation of liberty, but in DE’s best interests therefore lawful.

DOLS - Deprivation of Liberty safeguards

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- Amendment to Mental Capacity Act introduced in the Mental Health Act 2007
- 1st April 2009
- Apply to people in E&W who have a mental disorder and lack capacity
- DOL only lawful if necessary:
  - In their best interests to prevent harm
  - Proportionate
  - No less restrictive alternative

Deprivation of Liberty

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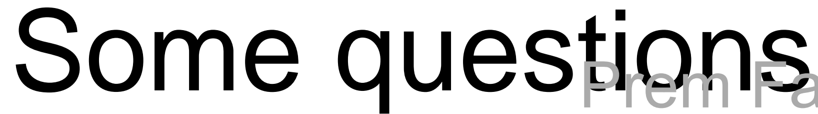
- No definition in Act or code of practice
- Locked doors?
- Physical restraint?
- Chemical restraint?
- Individual circumstances – degree/intensity not nature/substance

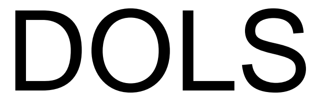
- Complete control over person’s care and movements
- Restricted contact with family
- Person continues to resist detention
- Family disagrees with detention

- Regular v PRN restraint



Some questions

- How often does restraint have to be used, how long and at what intensity?
- Does anyone – the person, their family or carers object?
- Does the restriction of liberty interfere with social contacts with family and friends?
- Are there any less restrictive options?



DOLS

- Where a person is deprived of their liberty the managing authority (Hospital or Care Home) must apply to the supervisory body (PCT or Local Authority) for authorisation.
- Urgent - MA can grant itself urgent authorisation. Lasts for 7 days.
- MA still needs to apply to SB for standard authorisation – lasts for up to 1 year
- DH website www.dh.gov.uk – standard forms

6 criteria/assessments

- Age – over 18
- Mental capacity – person must lack capacity for the material decision
- Mental health- person is suffering from a mental disorder [as defined by MHA]
- No refusals- does not conflict with valid ARDT, LPA or CoP appointed deputy
- Eligibility – should MHA be used?
- Best interests [prevent harm and proportionate].

Role of IMCA

- If no family or friend to represent the person for whom a DOLS authorisation has been requested
- Any person subject to a DOLS authorisation who has no relevant person’s representative
- To support the relevant person’s representative as an advocate

Appeals procedure

- IMCA has to be involved in assessment process if no family or friends to advocate for the patient
- PALS
- Formal complaints procedure
- Patient’s representative [RPR] appointed whilst under DOL order can request a review at any time
- Last resort - Court of Protection

Remember

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- Restriction and/or deprivation of liberty only lawful to prevent harm or enable treatment/care in the person’s best interests.
- Deprivation of liberty authorisation only does what it says on the box.
- Treatment /care can only be given in accordance with the other safeguards in the Mental Capacity Act.

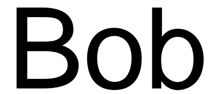
Scenario from code of practice

- Patient with alcohol related dementia
- Lives in care home
- Goes out to pub and comes back drunk
- Care home staff feel he should not be allowed out to pub
- Daughter says that would be deprivation of liberty
- Care home required to provide an escort to take him to the pub 3 x week for limited quantity of alcohol.

Important

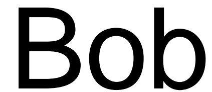
- Concern re DOL should not prevent urgent medical treatment
  - 2.11- actions immediately necessary to prevent harm not necessarily DOL
- Temporary restraint to provide emergency treatment is not DOL
- Locked doors alone do not signify DOL
- If considering DOL also consider MHA

Some cases for discussion



Bob

- 70 years old, acute SOB, type 2 resp failure, drowsy, pyrexia, few chest signs,
- History of falls
- inpatient at local MH Trust under section 3
- Chronic schizophrenia
- Hypertension, type 2 DM,
- Heavy smoker



Bob

- Needs NIV
- Medics want to do CTPA and CT brain
- Patient is rousable and agitated, pulling out tubes and refusing interventions
- Only relative is a sister who is abroad

How should the medical team proceed?

- Does he have capacity to refuse medical treatment?
- Should we use restraint?
- Is this deprivation of liberty?
- What about an IMCA?

Mr T

- Long admission with infected ulcers, sacral sore, lymphoedema and self neglect.
- History of paranoia
- Rehab, patient and partner re-housed, large POC
- Discharged home
- Re admitted 8 days later with LRTI
- Now medically fit, ready for discharge

Mr T

- Mr T demands to go home – *'You can't keep me a prisoner here'*
- But his partner does not want him back
- Mr T was non compliant with carers and district nurses
- Partner has agoraphobia and is very deaf.
- District nurses feel he should not be discharged
- MMSE 27/30

What are the issues

How can they be resolved?

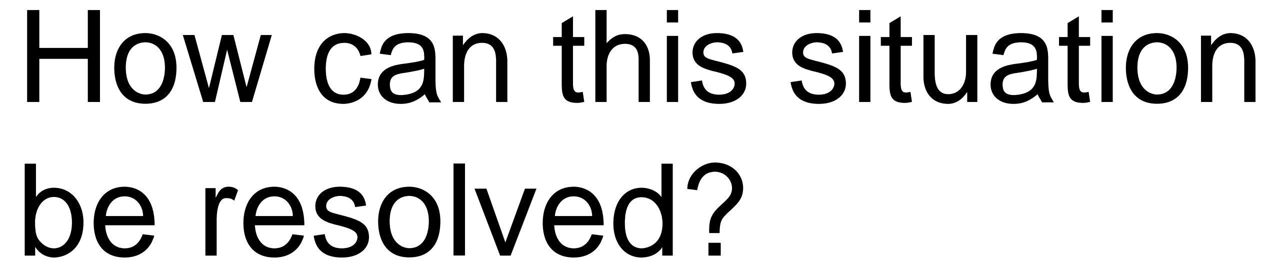
- Does he have capacity to make a decision re discharge?
- What is the role of the psychiatrist?
- Is this Deprivation of Liberty?
- Should we involve IMCA?

Mrs M

- Admitted delirium secondary to urinary sepsis.
- History of absence seizures, cerebrovascular disease, COPD and mild cognitive impairment
- Lives with daughter, QDS POC plus hoist.
- Recurrent admissions
- Daughter has difficult relationship with carers.

Mrs M

- Now fit for discharge
- But intermittently drowsy
- SS concerned she is a vulnerable adult and concerned about sending her home
- Patient expresses a wish to return home
- Medical team and SS disagree about patient’s capacity to decide.
- Daughter adamant she wants her mother home


How can this situation be resolved?

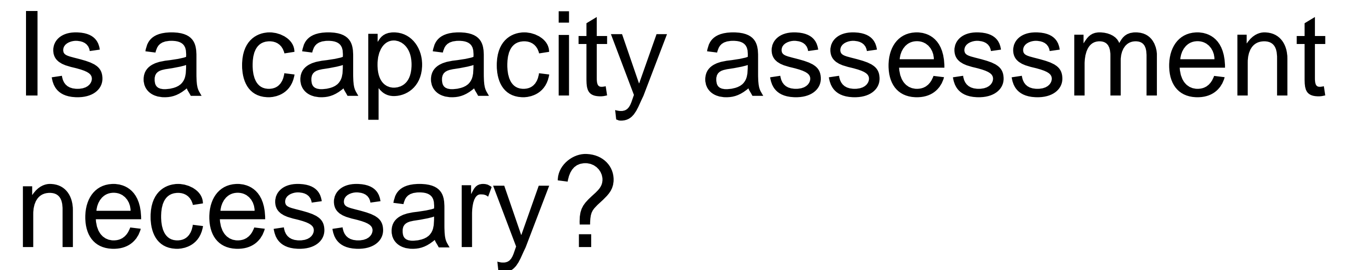
- Which principles of MCA are relevant to this situation?
  - What is the decision that is required?
  - Does M have capacity to make this decision?
  - Who is the decision maker?

- Is this DOL?

- 90 years old
- Admitted with D&V which resolves spontaneously
- Patient appears compos mentis on PTWR, consultant says discharge.
- Just before she goes home neighbour phones to report concerns re 45 year old boyfriend who seems to be taking a lot of money from her.

Miss P

- Vulnerable adult alert
- Visited at home by SW and RMN
- 25/30 MMSE, 7/14 FLT
- Seems anxious and poor concentration, reluctant to answer questions about finances
- Says she likes to be generous to her friends '*you can't take it with you*'.
- Social services still concerned and want geriatrician to do capacity assessment re finances



Who should do it?

'How to assess capacity to make a will' Jacoby and Steer BMJ 2007

Finally – remember the little green men!