GP FAQ - 19 June 2015

Section 1: Decision making

What is mental capacity?

Mental capacity is a person's ability to make a particular decision at a particular time. Capacity is not an 'all or nothing' thing. It is decision and time specific. A person may have capacity to make decisions about some matters, or to make decisions at some times.

You must assume that a person who is aged 16 years or more has capacity to the make the decision in question, unless you establish that they lack capacity using the two-stage test. This is the first principle of the Mental Capacity Act.

What is the test for capacity?

The test for capacity involves two stages.

Stage 1 - diagnostic test

This tests whether a person has an impairment of, or a disturbance in the functioning of, the mind or brain. Examples include significant learning disabilities, dementia and the long term effects of brain damage.

Stage 2 - functional test

This tests whether the impairment or disturbance causes the person to be unable to make a particular decision at the time it needs to be made. A person is unable to make a decision for himself if he is unable to:

- understand information relevant to the decision
- retain that information for long enough to take the decision
- use or weigh that information as part of the decision-making process; or
- communicate the decision (by talking or any other means)

How certain do I need to be, when I assess a person's capacity?

Your decision about a person's capacity is on a balance of probabilities, which means more likely than not.

If you conclude that a person lacks capacity, your belief must be reasonable. This is an objective test and your record of your capacity assessment must support this. Holding a reasonable belief depends upon having taken reasonable steps first (reflecting your professional status, the significance of the decision to the person and its urgency).

For a copy of the CCG mental capacity assessment form, click here.

Am I entitled to seek a second opinion about capacity?

More complex decisions may justify a second opinion about a person's capacity. However, the final decision must be made by the person intending to make the decision or carry out the action on behalf of the person who lacks capacity.

Sometimes, you may be asked to provide a second opinion about capacity. For example, a solicitor or other legal professional must decide whether the client has the capacity to make a will but, in cases of doubt, they may ask you to provide an opinion.

I sometimes let family members translate. Is that alright?

Whether you are seeking consent from a person with capacity to make a decision, or assessing their mental capacity, it is important to share information about the decision and to communicate clearly. Best practice is to use an independent translator.

I have been asked to provide a certificate for a lasting power of attorney. Can I?

As a doctor, you may be asked by your patient (the donor) to be a certificate provider if he intends to make a lasting power of attorney. If you agree to be a certificate provider, your role will be to confirm that they understand the lasting power of attorney instrument, they have not been put under pressure to make it and that it has not been completed fraudulently. You should also have no doubt about the person's identity.

It is important to fully understand what the role of a certificate provider involves before you agree to do it. You may refuse to do it if you do not feel able to confirm everything that you are being asked to certify.

To listen to a podcast about being a certificate provider and what to ask the person, please click here (opens external window).

Do Enduring Powers of Attorney (EPA) still exist?

Yes, but no new ones have been entered into since the Act came into force fully in 2007.

What power does an attorney for health and welfare have?

An attorney under a registered lasting power of attorney for health and welfare can make decisions about where and with whom the person should live, their day to day care and - importantly - may consent to or refuse medical examination of treatment on the person's behalf.

An attorney may refuse treatment, but may only refuse life-sustaining treatment if the person has specifically granted them the power to do so, in the lasting power of attorney document.

Before making a decision, an attorney must be satisfied that the person lacks capacity to take it and they are making the decision in the person's best interests.

Can I ask to see the power of attorney document?

Yes. You may wish to satisfy yourself that the attorney has been appointed, the document has been registered and it covers the specific decision in question.

Can I challenge an attorney's decision?

An attorney must make follow the Act's five principles and make decisions in the best interests of the person. If you think the attorney is not doing this, discuss this with the attorney first. It may be possible to resolve any disagreement. If not, you may consider referring the matter to the Office of the Public Guardian.

Ultimately, it is possible for the Court of Protection to remove an attorney if they are not acting in the person's best interests.

What is a deputy?

A deputy is someone appointed by the Court of Protection to make ongoing decisions about the health and welfare, or property and finances, of a person who lacks capacity.

A deputy for health and welfare will be required in the most difficult cases where important or necessary actions cannot be carried out without the Court's authority or there is no other way of settling the matter in the best interests of the person.

Does an advance decision need to be in writing?

This depends upon what the advance decision is intended to refuse.

First, before a healthcare professional applies an advance decision, there must be proof that the advance decision exists, is valid and is applicable to the current circumstances.

Second, while the starting point is that there are no particular formalities about the format of an advance decision (it may be written or verbal), a refusal of life-sustaining treatment must be written, signed, witnessed and should contain a clear, written statement that the specific treatment is to be be refused even if life is at risk.

Can I witness the person's signature on an advance decision?

A person who makes an advance decision to refuse life-sustaining treatment must sign in the presence of a witness. The witness must then sign the document in that person's presence or, if the person is unable to sign, the witness can witness them directing someone else to sign on their behalf.

The witness is witnessing the person's signature (or the signature of someone directed by them to sign on their behalf) rather than certifying that the person has capacity to make the advance decision. You may witness the person's signature. However, it is a good idea to get evidence of a person's capacity to make an advance decision if their capacity is in doubt and there is a possibility this may be challenged in the future. Record your assessment clearly.

Should an advance decision be reviewed?

When establishing whether an advance decision applies to current circumstances, healthcare professionals should take special care if the decision does not seem to have been reviewed or updated for some time.

If the person's current circumstances are significantly different from those when the decision was made, the advance decision may not be applicable. For this reason, it is a good idea for the person to review an advance decision regularly.

Is an Independent Mental Capacity Advocate (IMCA) a decision maker?

No. A decision maker is the person who has the power to take the decision or action being proposed for or on behalf of the a person who lacks capacity to take it. This will be you in relation to the provision of medical treatment.

An IMCA must be appointed to support and represent a person where a decision is about serious medical treatment or a long term accommodation move and the person has no-one appropriate that you can consult (other than a professional or paid carer).

What is the relationship between the Mental Capacity Act 2005 and the Mental Health Act 1983?

Mental capacity and mental disorder are distinct. A person may be suffering from mental disorder (within the meaning of the 1983 Act) but be perfectly capable of making healthcare decisions.

If admission to hospital for assessment or treatment for mental disorder is necessary for a person who lacks capacity to consent to it, professionals need to think about using the 1983 Act where providing the necessary care or treatment:

- will unavoidably involve depriving the person of their liberty and the deprivation of liberty safeguards cannot be used (for example, because the person is aged under 18 years); or
- cannot be safely or effectively delivered under the 2005 Act (for example, where the person's capacity fluctuates and he is not expected to consent to treatment if he regains capacity)

Section 2: Identifying a deprivation of liberty

What is a deprivation of liberty and where can it occur?

Deprivation of liberty is the term used in the European Convention on Human Rights meaning circumstances when a person's freedom is taken away. It is defined by the *acid test* (next section).

When a deprivation of liberty results from the delivery of health or social care services, the state (local authority and NHS) must ensure this is authorised.

Deprivation of liberty can occur anywhere - for example, in a hospital, care home, supported living arrangement in the community or in a person's own home.

Please see the section below entitled *Setting-specific factors* for more information about what may constitute a deprivation of liberty in different settings.

Depending upon where a deprivation of liberty occurs, this may be authorised under the Deprivation of Liberty Safeguards or by the Court.

What is the acid test for a deprivation of liberty?

The acid test is used to decide whether a person is being deprived of their liberty and is made up of three parts. To be deprived of their liberty, a person must:

- be under continuous (complete) supervision and control;
- not be free to leave; and
- lack capacity to consent to the arrangements made for their treatment or care.

All three elements are necessary.

Acid test 1: continuous (complete) supervision and control

There is no deprivation of liberty if a person is not under continuous (complete) supervision and control. This should not be interpreted as meaning that a person must be under 24 hour monitoring. Support given in the person's best interests can amount to control.

In a practical sense, a person *may* be under continuous (complete) supervision and control if the person or body responsible for the person has a plan in place so that they know:

- where the person is and what they are doing at any one time; and
- how to respond if they are not satisfied they know where the person is and what they are doing.

Relevant factors include staff:

- having complete control over the person's care or movements for a long period of time
- overseeing the person's decision making or allowing aspects of decision making to the person at their discretion
- making all decisions about a person, including choices about assessments, treatment and visitors and controlling where they can go and when

Acid test 2: not free to leave

Macro

A person will not be free to leave the placement or place of treatment if:

- they are able *permanently* to relocate from the placement or place of treatment only with the permission of those responsible for their care or treatment; and
- steps will be taken to bring about their return if they try to leave the placement *permanently* and do not return of their own accord.

The person may seem happy to stay but the issue is how staff would react if the person tried to leave, for example, to live with a carer or family member.

Micro

A person who is not free to come and go as they please *temporarily*, with or without help, and without the permission of those responsible for their care or treatment, is subject to a restriction upon liberty. This may amount to a deprivation of liberty, but it would depend upon taking all other measures into account.

Not being free to come and go as they please is also likely to be relevant to whether the person is under continuous (complete) supervision and control.

Ability or attempts

Importantly, freedom to leave should not be confused with ability to leave or attempts to leave. This is an important steps to equalise the right to liberty, regardless of physical or mental disability.

Acid test 3: lacks capacity to consent

The person must lack capacity to consent to arrangements made for their treatment or care, at the time the decision needs to be taken. The two-stage test for assessing mental capacity is used to determine this.

A person who has capacity and has consented to these arrangements does not fall within the scope of the European Convention and therefore the Deprivation of Liberty Safeguards.

Compliance, objection, benevolence not relevant

The following factors are not relevant to deciding whether a deprivation of liberty is *occurring*:

- the person's compliance with, or lack of objection to arrangements made for their treatment or care
- the purpose of the placement
- the relative normality of the placement, given the person's needs (meaning the person should not be compared with anyone else)

Compliance or lack of objection, and the purpose of the placement are still relevant to deciding whether a deprivation of liberty is in the person's *best interests*.

If a person strongly resists the arrangements, the more intensive the measures put in place are likely to be. This may increase the likelihood of a deprivation of (rather than a restriction upon) liberty.

Non-negligible period of time

To be deprived of their liberty, a person must be confined to a particular restricted place for a non-negligible period of time. The length of time they are subject to these restrictions is therefore an important consideration and will vary, taking into account the intensity of the measures put in place.

For example, you should not assume that if a person is confined for less than 2 days on an acute ward, this amounts to a negligible period of time.

What should be my starting point?

Always start by considering whether arrangements made for the treatment or care of a person who lacks capacity to consent to them are in their best interests, having regard to less restrictive alternatives. Then, if these arrangements amount to a deprivation of liberty and are the responsibility of the state, they must be authorised.

Do I need to be certain that someone is being deprived of their liberty?

No. The important thing it to be able to identify when someone is at risk of a deprivation of liberty. If there is a risk, this should trigger further assessment.

Section 3: Authorising a deprivation of liberty: hospital and care home settings

What are the Deprivation of Liberty Safeguards?

The Deprivation of Liberty Safeguards are the legal framework under the Mental Capacity Act 2005 for people:

- who need to be deprived of their liberty in a hospital or care home in their best interests;
- to be given necessary treatment or care; and
- who lack the capacity to consent to the arrangements made for their treatment of care.

If a person is deprived of their liberty other than in a hospital or care home, this must be authorised by a Court order.

What is the difference between an urgent and standard authorisation?

Urgent authorisation

This is an authorisation given by the hospital or care home manager (known as the managing authority) for up to 7 days. The purpose is to authorise a deprivation of liberty immediately while an application for a standard authorisation is processed. It can be extended by up to a further 7 days in exceptional circumstances.

Standard authorisation

This is an authorisation given by the local authority (known as the supervisory body) after completing the statutory assessments, giving lawful authority to deprive a person of their liberty in the hospital or care home.

Who should apply for a Deprivation of Liberty Safeguards authorisation?

The managing authority must apply for a standard Deprivation of Liberty Safeguards authorisation. This is the person or body with management responsibility for the hospital or care home in which a person is, or may become, deprived of their liberty. In reality, this means the hospital or care home manager. The application is made to the supervisory body (local authority).

What does the supervisory body do in response to an application?

The supervisory body will commission six assessments to decide whether a person fulfils the criteria for a standard authorisation under the Deprivation of Liberty Safeguards:

- Age - the person must be at least 18 years of age)
- No refusals - a standard authorisation would not conflict with another decision-making instrument, such as an advance decision to refuse medical treatment)
- Mental capacity - the person lacks capacity to consent to the arrangements for their treatment or care
- Mental health - the person has a mental disorder within the meaning of the Mental Health Act 1983
- Eligibility- the person is not, or should not be, within the scope of the 1983 Act
- Best interests - the person is being deprived of their liberty and it is in their best interests for this to be authorised

If all six assessments are satisfied, a standard authorisation will be granted.

Standard authorisation - what do I need to know?

Duration

A standard authorisation can last no longer than 12 months.

Scope

A standard authorisation makes a deprivation of liberty lawful. It does not give authority to provide the treatment or care the person needs, which must be given with the person's consent (if they have capacity) or in their best interests (if they do not).

Conditions

The standard authorisation will contain conditions which staff must follow, designed to secure the deprivation of liberty, limit its effect or work towards bringing about its end.

Representative

The representative is appointed to support the person in relation to the authorisation. Usually, this is a family member or friend but in some cases may be a paid representative.

Section 4: Authorising a deprivation of liberty: domestic settings

What is a domestic setting?

A domestic setting refers to a placement in a supported living arrangement in the community, shared lives schemes (formerly known as adult placements) and extra care housing.

How is a deprivation of liberty authorised in a domestic setting?

A deprivation of liberty requiring authorisation can occur in a domestic setting where the state (local authority or CCG) is responsible for imposing the arrangements for the person's care.

Where care is being provided in the community, a deprivation of liberty needs to be authorised by the Court of Protection (the Deprivation of Liberty Safeguards do not apply as these settings are not likely to constitute a care home for the purpose of registration).

The state responsibility requirement is likely to be satisfied if the care or health package has been arranged or commissioned by a CCG. In these circumstances, the CCG will meet the cost of the application to the Court.

Unlike the Safeguards, where the minimum age threshold is 18 years, a person need only be 16 years of age to be subject to a Court-authorised deprivation of liberty.

Can a person be deprived of liberty in their own home?

It is not currently clear whether a person can be deprived of liberty in their own home (whether owned or rented by them, or by relatives with whom they live).

Until the picture becomes clearer, it is better to take a cautious approach and assume that it is possible a person can be deprived of their liberty in their own home.

While the state responsibility requirement is likely to be satisfied if the care package has been arranged or commissioned by a CCG, a recent case suggested that this responsibility could be diluted by the strong role played by a pro-active and caring family, indicating this is a rapidly changing area that should be monitored closely.

If you encounter circumstances where you think there is a risk of a deprivation of liberty occurring in a person's own home, and the state is responsible, please raise this with the Adult Safeguarding Lead at the CCG.

Is it a deprivation of liberty to take a person to hospital by ambulance?

Taking a person who lacks capacity, either from their home or from another location, by ambulance to hospital in an emergency will not usually amount to a deprivation of liberty, as long as it is in the person's best interests.

However, it could amount to a deprivation of liberty if, for example, the journey is exceptionally long, sedation is required or it is necessary to gain entry to the person's home with the assistance of the police in order to remove them from their home and into the ambulance. If the action will amount to a deprivation of liberty, authorisation from the Court of Protection (rather than under the Safeguards) would be required.

It must not be assumed that an authorisation granted under the Safeguards in respect of one hospital can be used to authorise that person's transfer to another hospital.

Is a patient in ICU being deprived of liberty?

This is a difficult area. The majority of patients in ICU lack capacity to make decisions about their care or treatment, restraint is often used, their care is closely monitored and they are there for a not negligible period of time. Depending on the circumstances, these factors may point towards a deprivation of liberty.

It may also be relevant whether the patient had capacity and consented to the arrangements prior to losing capacity (which are then delivered broadly as anticipated).

Legal advice is likely to be needed in respect of these cases.

Section 5: Deprivation of Liberty: what do I need to do now?

What do I need to do now?

There are several steps you can take now.

Restrictions

Be mindful of the need to reduce restrictions and to promote liberty in care plans.

Policy

Ensure that your Practice has an up to date policy on deprivation of liberty.

Care home

Consider whether the home has applied to authorise the deprivation of liberty of any resident whose care arrangements mean they could satisfy the acid test. If you have concerns, speak with the care home manager. Monitor this. If you are not happy with the manager's response, raise your concerns with the Adult Safeguarding Lead at the CCG.

Domestic settings

Review the number of patients whose care arrangements in domestic settings could satisfy the acid test. Speak with the manager of the setting or raise your concerns with the Adult Safeguarding Lead at the CCG.

Codes of Practice

You are under a legal duty to have regard to the MCA and DoLS Codes of Practice and your Practice should hold a copy of each for staff to use.

Section 6: Death and deprivation of liberty

Does the Coroner need to be notified?

Yes. It is the responsibility of the care home or hospital manager to notify the Coroner when a person dies while under a Deprivation of Liberty Safeguards authorisation, because this is treated as a death while in state detention. As the matter must be referred to the Coroner, the GP is unable to sign the death certificate.

The Coroner must also be notified if the person was under a Court-authorised deprivation of liberty at the time of death.

This does not mean that every inquest will result in calling witnesses because uncontroversial cases may be dealt with in open court on the papers only without witnesses having to attend. The Coroner's office will request information about the person's health before death, whether the death was expected and will issue the death certificate or refer for post mortem

If a hospital or care home has applied for an authorisation but this has not yet been granted at the date of death, it would also be sensible to notify the Coroner.

Where the authorisation relates to a care home and the person is removed to a hospital and dies there (or in transit), an investigation must be commenced.

There is no requirement for a jury if the death is from natural causes.