Durham Safeguarding Adults Partnership

The Mental Capacity Act and safeguarding adults: what good looks like.

Best Interests Decision Making Process

All about the Mental Capacity Act 2005 (MCA) and safeguarding adults in a bitesize series: more coming soon.

Click on a topic to go straight there.

Contents

Why this topic?

This guide to the Best Interests decision making process follows on from the guide on Capacity Assessment which should be read first.

Analysis of Safeguarding Adult Reviews: April 2017 - March 2019 | Local Government Association

A National Analysis of 231 Safeguarding Adult Reviews was published in December 2020. Safeguarding Adult Reviews (SARs) take place where an adult has died or been seriously harmed, and there has been abuse or neglect, in order to learn about practice improvements and working better together.

The National Analysis found that nearly all SARs identify a lack of use of the Mental Capacity Act (MCA) 2005 or it not being used properly, in particular: capacity assessments, **best interests decisions**, and (respectful) challenge of decisions.

Human Rights

The MCA, the Code of Practice and much of the work of the Court of Protection turns on upholding a person's human rights.

"A conclusion that a person lacks decision-making capacity is not an 'off-switch' for his rights and freedoms."

Wye Valley NHS Trust v Mr B, Capacity is not an off-switch – Mental Capacity Law and Policy

Human rights are for everyone

'Human rights are for everyone, including the most disabled members of our community, and that those rights include the same right to liberty as has everyone else…The whole point about human rights is their universal character…They are premised on the inherent dignity of all human beings whatever their frailty or flaws…"

https://www.supremecourt.uk/cases/docs/UKSC_2012_0068_Judgment.pdf

The Human Rights Act 1998 sets out the Articles of the European Convention on Human Rights.

See also the British Equality and Human Rights Commission

The Articles particularly relevant to Best Interests decisions are:

2. Right to life
3. Freedom from torture and inhuman or degrading treatment
5. The right to liberty and security
8. Respect for your private and family life, home, and correspondence.
12. Right to marry and start a family
14. Protection from discrimination in respect of these rights and freedoms

Everybody carrying out a statutory function – that is, employed in or commissioned or funded by the statutory sector, must protect individual's human rights, including when people are at risk from another person.

The five Mental Capacity Act 2005 Principles

The first three out of the five statutory principles written in the first section of the Mental Capacity Act support capacity assessment:

1. **A person must be assumed to have capacity unless it is established that they lack capacity.**
2. **A person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success.**
3. **A person is not to be treated as unable to make a decision merely because they make an unwise decision.**

The fourth and fifth principles apply after a capacity assessment has found the person does not have capacity to make a particular decision:

4. **An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.**
5. **Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.**

The Mental Capacity Act 2005

- The MCA Statutory Code of Practice was published in 2008. Staff working with or caring for adults who lack capacity to make decisions for themselves have a legal duty to consider to Code of Practice.
- The Deprivation of Liberty Safeguards (DoLS) is an amendment to the Mental Capacity Act 2005 (passed by being inserted into the Mental Health Act 2007 which was being amended in parliament at the time). DoLS is now in Schedule A1 to the Mental Capacity Act 2005.
- DoLS Code of Practice 12369 Mental Capacity 18th.indd (cqc.org.uk)

https://www.legislation.gov.uk/ukpga/2019/18/enacted/data.htm

- Much case law has been determined since the Act was passed and the Code of Practice written, which clarifies how the Act should be applied. Court of Protection Hub produces summaries of cases and relevant decisions, which are taken account in guides produced by 39 Essex Chambers.

Future changes

- The Mental Capacity (Amendment) Act 2019 will introduce Liberty Protection Safeguards which will replace DoLS and apply to people aged 16+ who lack capacity to consent to their arrangements, and in community settings.
- Implementation is delayed due to Covid-19.

- A new Code of Practice combining both the MCA Code of Practice and the DoLS Code of Practice is due to be published for consultation before implementation.
- There will be updates to this guide with the new Code and regulations when they are available.

What is a Best Interests decision?

Once a person is assessed as lacking capacity to make a specific decision or give informed consent to care or treatment at the time it needs to be made, (having had all practicable steps taken to support them), then that consent may need to be given for them or on their behalf.

Consent could be determined if a Living Will, also known as an Advance Decision to Refuse Treatment (ADRT), has been made (see guide on Next of Kin, Living Wills, Attorneys…).

Best Interests decision making is not a clinical decision – is a legal decision and is a process that should be applied and then properly recorded

Key concepts: reasonableness, practicality, appropriateness – nuances that along with the principles mean each Best Interests decision will be individual, context dependent, and potentially time limited.

Exceptions to Best Interests process

Some decisions can never be made for someone or on their behalf using the Mental Capacity Act:

- Family and relationship decisions: consent to marriage or civil partnership, give up a child for adoption, divorce
- Consent to or engage in a sexual relationship
- Voting.

If the Court of Protection has found that a person does not have capacity to take these decisions for themselves, it can make orders on protective measures such as in relation to protecting someone from having a sexual relationship to which they cannot consent.

The Best Interests process cannot override a Living Will, which may be valid even if made verbally (except for refusing life-sustaining treatment which must be specific, in writing and witnessed).

When does Safeguarding Adults and Best Interests decision making overlap?

Safeguarding adults duties apply if an adult with needs for care and support is at risk of or experiencing abuse or neglect and cannot protect themselves from it. A capacity assessment may have been initiated because of existing safeguarding concerns. Where adults are found to lack capacity for certain decisions they are at more risk of abuse or neglect. Examples include:

- Domestic abuse – victim/survivor in the abusive relationship develops dementia and then loses capacity in relation to contact and to risk

- Adult has recently moved to residential accommodation and disclosed past familial abuse - concerns about family visiting (see Ann Craft Trust project)
- Adult with capacity making unwise decisions; disregarding harm as it was not their priority, then gradually in decline / condition deteriorates and no longer has capacity…
- Self neglect: refusal of care services, health treatment, fire risks…
- Where adult lacks capacity to consent to or decide on proposed safeguarding action during/after S42 enquiry
- Domestic abuse, coercion and control – adult was targeted because they have a learning disability
- Adult with learning disabilities targeted and groomed for sexual exploitation, home invasion (cuckooing), other criminal exploitation, and radicalisation
- Older isolated adults targeted by fraudsters
- An attorney is being neglectful or is misusing their financial powers
- Where closed cultures have developed or are at risk of developing.

"incapacitous adults…are particularly vulnerable to emotional, financial and psychological abuse".
A County Council v LW & Anor [2020] EWCOP 50 (22 July 2020) (bailii.org)

Who is the decision maker?

It depends…who wants a decision made or action taken, or who can give or refuse consent?

The Best Interests decision maker could be:

- Family members or care workers for informal day to day decisions
- Attorneys appointed under an active and valid Lasting Power of Attorney (LPA) for personal welfare including healthcare
- Attorneys appointed under an active and valid LPA or Enduring Power of Attorney for financial affairs (including contracts such as a tenancy)
- A court appointed welfare Deputy who can make Best Interests decisions, but only as set out in their powers by the Court of Protection
- The relevant consultant, health care or social care professional, housing officer, police officer or other professional, once they have assessed the person as having a lack of capacity for that decision at that time
- A registered Best Interest Assessor to authorise a deprivation of liberty using the DoLS (usually a registered professional in local authority)
- The Court of Protection.

The decision may be able to be made by an attorney or deputy if a valid Lasting Power of Attorney (LPA) or deputyship Court order gives them the relevant powers. You must check to find out if there is an LPA and if it is valid (see guide on Next of kin, Living Wills, Attorneys, Deputies and the Office of the Public Guardian).

Staff should note that **Next of Kin has no legal status**; family members cannot give consent for major decisions such as for treatment, care, or about finance if they do not have the relevant legal authority.

If the above arrangements are not in place or are not valid, then the Best Interests decision will need to be made by an appropriate person. Best Interests decision makers could include:

- The GP prescriber about consent to take a medicine

- The nurse who is actually giving the vaccination
- Consultant seeking consent about chemotherapy
- Family member or care worker about suitable clothes to wear in cold weather
- The district nurse on the doorstep who wants consent to go into someone's home
- Housing Officer asking for a tenancy agreement to be signed
- Social worker concerned about smoking, fire risk, and use of a smoking apron
- Ambulance crew, to determine if someone has capacity to refuse to give consent for admission to hospital
- Police officer if no other relevant professionals are present.

"What this means is that a range of different decision-makers may be involved with a person who lacks capacity, to make different decisions"

Code of Practice

Some Best Interests decisions must always go to the Court of Protection to determine, for example about organ donation.

Involvement in 'intrusive research' which would require consent to be lawful must go to an approved body, such as an NHS Research Ethics Committee (REC) or the Social Care REC. Intrusive research includes research in healthcare, social care and criminal justice settings, and research methods such as processing personal data, questionnaires, interviews, and observation.

MCA section 30-34

Mental Capacity Act - Health Research Authority (hra.nhs.uk)

Advocacy

An advocate "stands in the shoes of the person" and speaks for them; they can make reports, but they are not the decision maker in a best interests decision. There are different types of advocate with differing roles.

Independent Mental Capacity Advocate (IMCA)

- IMCAs must be appointed and consulted to support someone who lacks capacity and has no one else to support them (other than paid staff) for all long-term changes to accommodation for example moving to a care home for more than 8 weeks or hospital for more than 28 days, for a deprivation of liberty, and for serious medical treatment.
- An IMCA may be arranged by a local authority or NHS organisation to support someone who lacks capacity to make decisions about safeguarding adults, even if there are family and friends who can be consulted.
- An IMCA may be instructed to support someone who lacks capacity to make decisions concerning care reviews, where no one else other than paid staff is available to be consulted.

MCA section 37 to 40

Care Act 2014 advocacy

The Care Act states that advocacy must be arranged for an independent advocate to represent and support an adult during a safeguarding enquiry or Safeguarding Adult Review (SAR) if:

- the person would have substantial difficulty in being involved,
- there is no one else who is suitable,
- and the person consents to the representative, or if they lack capacity the local authority is satisfied it is in their best interests.

The IMCA and Care Act advocate may be the same person.

County Durham Advocacy Service provides Independent Mental Capacity Advocacy and Care Act advocacy

Visit Rethink - County Durham Advocacy Service

Call **01388 766310**

Email County Durham Advocacy Service

SCIE has a collection of tools to support use of advocacy: https://www.scie.org.uk/advocacy

The Best Interests decision making process and check list

Under the MCA principle 4 decisions must be in the Best Interests of the person concerned; not what might be best for others. The matters to consider in the Best Interests decision making process are set out in the MCA itself in Section 4, often known as the Best Interests check list and in Chapter 5 of the Code of Practice.

- Within the process you need to find out what that person would have wanted for themselves – not what relatives want now, not what you as a professional believe to be right.
- Involving and speaking to the person is always best. Can you build up a relationship of trust over time? Is there someone else who has a good relationship with the person and can help? Or who could build it up, over time?
- A Best Interests decision that departs from what the person would have done needs to be justifiable; the more it departs the 'more compelling' the reasons need to be. For example in safeguarding adults, proportionate action to prevent harm would be justifiable even if was something that the person would not have consented to when they had capacity.
- Best Interests is not the same as what the person wants, nor carrying on with what someone was doing. You cannot allow something to continue that is not in someone's best interests such as risk taking or self neglect, even if that's what the person chose to do before when they had capacity for that. The person's previous views, actions and beliefs are a substantial part of the Best Interests process, but legally you cannot make an unwise decision for someone else.

Less restrictive

Principle 5 about the Best Interests decision is can it be "effectively achieved in a way that is less restrictive of the person's rights and freedom of action"? The Principle does not say 'least', and the least restrictive option may not be in the person's best interests. But restrictions on a person's human rights must be as limited as possible while meeting the need.

[In the Mental Health Act 1983 (MHA) the term used is least restrictive; see below for some of the key differences with the MCA and MHA.]

Best interests check list

Avoid discrimination.

- You must not determine the person's Best Interests merely on the basis of age, appearance, their condition, or behaviour.

Consider all relevant information. Take steps to consider:

- The person's past and present wishes and feelings
- Encourage the person to participate as fully as possible
- Values and beliefs that would influence them, especially any written statement made when they had capacity
- Any other factors the person would consider.

Take into account, if reasonable and appropriate to consult them, the views of:

- Anyone named by the person to consult about the matter
- Anyone caring for the person or interested in their welfare – this includes paid care workers
- Attorney or court appointed deputy.

Consider if the person might regain capacity

- And when that might be – can the decision wait until then?

Appearance, conditions, behaviour

- Appearance includes all aspects of the way people look e.g. scars, muscle spasms, facial features, tattoos, piercings, how people dress.
- Conditions covers:
  - All disabilities, age related illness or frailty
  - Behaviours – shouting, gesticulating, being withdrawn, repetitive actions, avoiding eye contact, temporary conditions such as being drunk.
- To be taken into account but not the only deciding factor.

Gathering information

- Consider who is concerned with person's welfare: Family? Neighbours? Care workers? Church? Voluntary organisations' staff?
- There is no hierarchy of consultation.
- If you suspect family abuse, the adult must be seen without family present, with an advocate if necessary. Beware coercion.
- What available options are there to consider?
- Consider a balance sheet approach.
- Do you need to hold a Best Interests meeting?

Establishing the person's views when consulting others.
This is about what the person would have wanted. If there is a Living Will, or an advance statement, the person's views might be very clear. Most people have not done these.

As with the capacity assessment, the person should be helped to be as involved as they can be, including using their preferred communication.

There is no hierarchy of consultation – be aware that a family member who lives abroad and does not visit is likely to have less relevant information than a care worker who visits daily.

If there have been previous capacity assessments and best interests decisions on a similar topic there may be relevant information about what the person would want and their values and beliefs, that can inform you now.

Sometimes relatives are unable to say what they think the person would have wanted because their own views are so strongly held.

"The most important fact to remember in this process is that the goal is to establish the patient's views, not the views of the informant. Obviously, it may be difficult to disentangle the two, but the distinction is vital".

One approach which can help relatives to understand the distinction is to ask the following three questions, in this order:

1. **"what do you want for the person?"**
2. **"what would you want for yourself if you were in the person's situation?"**
3. **"what do you think the person would want?"**

It is the answer to the last point that should be taken into account in best interests decision making.

'Guide for clinicians (and anyone else) about conversations with families to help elicit information about P's values etc - in the Best interests decision making process' https://cdoc.org.uk/publications/resources-for-families-and-practitioners/

Covid-19 Vaccinations
There were three Court of Protection cases early in 2021 where relatives were objecting to a person resident in a care home having the Covid-19 vaccination. The judgements illustrate the Best Interests decision making process succinctly. In each case it was found to be in the person's overwhelming best interests to have the vaccine (and neither person had needle phobias nor were worried by the process).

Decision that it is in Mrs E's best interests to have a Covid-19 vaccination, January 2021
E (Vaccine) [2021] EWCOP 7 (20 January 2021) (bailii.org)

Decision that it is in V's best interests to have a Covid-19 vaccination February 2021
SD v Royal Borough of Kensington And Chelsea [2021] EWCOP 14 (10 February 2021) (bailii.org)

"Strongly held views by well-meaning and concerned family members should be taken into account but never permitted to prevail nor allowed to create avoidable delay."

Mr Justice Hayden

Decision that it is in CR's best interests to have the vaccination, March 2021
CR, Re [2021] EWCOP 19 (12 March 2021) (bailii.org)

"but with the important caveat that I am NOT authorizing physical intervention in order so to do."

His Honour Judge Butler

Relevant information for different types of decision

The relevant information that must be understood in a capacity assessment is also useful to inform a Best Interests decision.

39 Essex Chambers have produced a guidance note, updated in November 2021.
39 Essex Chambers | Mental Capacity Guidance Note Assessment - 39 Essex Chambers | Barristers' Chambers

Or go direct to
https://www.39essex.com/sites/default/files/Mental-Capacity-Guidance-Note-Relevant-Information-for-Different-Categories-of-Decision-November-2021.pdf

Weighing the pros and cons – the balance sheet approach

Use of a balance sheet is suggested in the Code of Practice. The advantages and disadvantages should be set out for each option that is actually available, including concrete practical implications for the person and factors such as the impact on relationships with family and care staff.

A balance sheet is a tool to help you structure your thoughts, come to your professional judgement, and record the process, not a calculator adding up sums. Best Interests is often about striking a balance with differing values, qualities, and options.

Best Interests needs a nuanced and reflective approach to understand and compare the qualitative and often conflicting values underlying, including those of the person.

In your records, set out why you attach more weight to one factor than another e.g. physical safety or mental and emotional well-being? You may need to tolerate uncertainty rather than knowing a right answer.

Balancing safety and happiness

Mr Justice Munby said in 2009 *Re MM* [2007] EWHC 2003 (Fam), [2009] 1 FLR 443

"Physical health and safety can sometimes be bought at too high a price in happiness and emotional welfare. The emphasis must be on sensible risk appraisal, not striving to avoid all risk, whatever the price, but instead seeking a proper balance and being willing to tolerate manageable or acceptable risks as the price appropriately to be paid in order to achieve some other good – in particular to achieve the vital good of the elderly or vulnerable person's *happiness*. **What good is it making someone safer if it merely makes them miserable?"**

A London Local Authority v JH & Anor [2011] EWHC 2420 was a case in which the judgement includes a table summarising the advantages of discharge to a nursing home or to Mrs H own home.

"The fact that this is an interim order does not justify "parking" Mrs H in a nursing home pending the final outcome, simply because it may be perceived as the safest option. It is a question of what is in her best interests at this stage."

The judgement found it was in her Best Interests to be discharged home with a care package.
A London Local Authority v JH & Anor [2011] EWCOP 2420 (25 August 2011) (bailii.org)

Blog describing Court making a best interests decision
A court-authorised hip replacement – Promoting Open Justice in the Court of Protection (openjusticecourtofprotection.org)

When to go to the Court of Protection

If there is disagreement about what is in a person's Best Interests which cannot be resolved, advice should be sought and timely application to the Court of Protection must be made.

The Court can direct protective measures in someone's Best Interests, authorise deprivations of liberty, and can direct for work to help someone maximise their functioning and potentially gain capacity in the future.

The Court can also consider if proposed or current treatment, care or other action is lawful giving assurance to staff and organisations.

While decisions about life sustaining treatment do not need to go to court if everyone is in agreement, if there is doubt an application must be made.

Mr Justice Hayden gave general guidance on "Applications relating to medical treatment" in January 2020. Situations would include where the decision is finely balanced, there is a difference of medical opinion, a lack of agreement and / or conflicts of interest.

What is a dispute?

Recognising when a situation is a dispute is essential to ensure cases go to the Court as and when they should. Some examples of disputes resolved at Court include:

- Daughter saying Mrs V should not have a Covid-19 vaccination
- Medical consultants have differing views about the best course of treatment
- Adult does not want to move out of hospital into supported living
- Husband would not allow medical staff to assess and treat his wife
- Local authority would not allow previous care worker contact with person

A key aspect of the Court of Protection is that there is a judge available 24 hours a day for urgent cases, and orders can be made swiftly.

Going to Court in a timely way

In several cases there has been criticism about a delay in taking the case to Court. In SD v Royal Borough of Kensington And Chelsea [2021] EWCOP 14 (10 February 2021) (bailii.org) the daughter said her mother should not have the vaccine on 13 December. The care home told the local authority on 12 January. In late January the GP told the daughter it was in V's best interest to have the vaccine. The daughter applied to court on 24 January to prevent it. The hearing was on 10 February. The judge was dissatisfied with the time taken.

"When an issue arises as to whether a care home resident should receive the vaccination, the matter should be brought before the court expeditiously, if it is not capable of speedy resolution by agreement."

Mr Justice Hayden

Review Best Interests decisions

A Best Interests decision taken in a clinical emergency may not continue to be in someone's Best Interests as time moves on. People and their conditions may change, improve, or deteriorate.

- One study of 79 people who were in a coma at two weeks found they were fully conscious after 12 months.
- Timely review should be built in to the process from the start, moving with people for example as they move from an intensive care unit to a ward through to discharge into rehab, or alternative accommodation.
- People may gain capacity by for instance learning to communicate
- Continuing treatment is an active decision and should involve the proper Best Interests processes.

"care handovers and discharge summaries should include a list of all decisions and prescriptions in place, with their individual review dates".

An invisible attention bias: A response to 'The elephant in the courtroom' – Promoting Open Justice in the Court of Protection (openjusticecourtofprotection.org)

Repeat prescribing or equipment replacement may need to be considered in the light of changing capacity and best interests.

In a Prevention of Future Deaths Report the coroner's concern was that:

"Elaine Inns continued to be prescribed a combination of medication including a number of powerful painkillers although it was well understood that she was also using alcohol in significant quantities whilst taking her prescribed medication. The evidence before the court also indicated that she would use the prescribed liquid morphine without clearly following the recommended dosage instructions. She continued to be prescribed it."

Elaine Inns: Prevention of future deaths report | Courts and Tribunals Judiciary

Delays in reviewing continued treatment

The Centre for Prolonged Disorder of Consciousness (people who are in a vegetative state or minimally conscious state) has highlighted delayed or missed opportunities when Best Interests decisions should be reviewed, which apply to many other situations:

- repeat prescriptions
- routine replacement of equipment such as feeding tubes
- to resolve doubt over continuing treatment, specifically Clinically Assisted Nutrition and Hydration (CANH).

On life sustaining treatment and best interests:

"the fundamental question is whether it is lawful to give the treatment, not whether it is lawful to withhold it".

Lady Hale

Para 20 https://www.supremecourt.uk/cases/docs/uksc-2013-0134-judgment.pdf

A Supreme Court judgment in 2018 found that it is not mandatory to seek judicial approval for decisions to withdraw CANH when everyone is in agreement that it is in the person's Best Interests. An NHS Trust v Y UKSC 46

If there are differing views about continuing treatment, which might involve the person's partner, family members, Attorney or Deputy, friends, or other professionals, and it cannot be resolved, it must go to the Court of Protection in a timely way.

In a Rehabilitation Matters blog on continuing medical treatment, Derick Wade quotes Mr Justice Hayden in March 2020 giving a view that can help in discussing the situation:

"To be clear, this is not a 'life and death' decision. Rather it is a decision on what sort of life P would wish to live from now until his death".

Mr Justice Hayden

Do no harm - Rehabilitation Matters

Restraint

Restriction, restraint, and depriving someone of their liberty can be seen as a continuum. Sometimes restraint can be necessary and appropriate, but often it is used in a way that is not. Restraint must only be used in a way that respects people's human rights. The BIHR worked with SCIE to produce two short films:

https://www.scie.org.uk/news/mediareleases/restraint-in-social-care

What is Restraint?

The Mental Capacity Act section 6 says that someone is using restraint if they:

- Use force – or threaten to use force – to make someone do something that they are resisting, or
- Restrict a person's freedom of movement, whether they are resisting or not.

Restraint may be:

- physical such as leading someone back into the house
- restrictive such as a locked front door
- chemical such as medication to control behaviour or rapid tranquilisation
- mechanical e.g. using straps on an ambulance stretcher, or cot sides on a bed.

Restraint is about actions that the person could consent to if they had the capacity to do so. A person cannot consent to abuse or serious harm.

When can restraint be used?

Restraint should be a last resort. Under the Mental Capacity Act Section 5 and 6; Code of Practice (Paragraph 6.11 – 6.19)) restraint is only lawful:

- if the person using it believes that it is necessary to prevent harm, and
- its use is a proportionate response both to the likelihood and the seriousness of the harm. (MCA Section 5)

Before each incidence of restraint staff must take reasonable steps to establish if the person lacks capacity and must reasonably believe the person lacks capacity about the matter, and it is in their best interests for the action to be taken (MCA Section 5):

- The person's capacity must be assessed every time
- The Best Interests decision making process must be followed

When carrying out restraint it must also:

- be minimal and
- for the shortest duration to prevent harm occurring.

Also note that a failure to restrain if it leads to harm of the person will result in an organisation being at fault, to blame.

How the MCA supports the protection of staff

The MCA if used properly protects staff when using restraint from civil liability for loss or damages and /or criminal prosecution, for instance for assault, battery, or false imprisonment.

The MCA does not give any protection from the use of force or restraint unless it is proportionate to prevent harm, properly using the relevant sections of the MCA.

What adults and their families say

Restraint is often experienced as frightening and distressing for people, and can cause more resistance, mistrust, upset, anger, and behaviour that challenges.

"It makes me feel powerless…what's the word I want…dehumanised. I don't feel like a real human being because people can forcibly medicate me and sit on me to make me do what they want."

Restraint can also be a positive experience:

"Staff hold me at my current care home, to keep me safe. They support me."

Lived Experience of Restraint, Seclusion and Segregation: Stories and Recommendations for Safer Care

https://www.cqc.org.uk/sites/default/files/20201021_rssreview_livedex.pdf

Organisational Abuse - A Chat With Bethany's Dad - Safeguarding Matters - Ann Craft Trust

Restraint and what is reasonable

What may be reasonable in a real emergency may be different when there is opportunity to step back and consider the situation. Best Interests involves consulting others and defusing situations – seeking a less restrictive option.

Lord Dyson said in the appeal hearing of a case where the police had not acted in the person's Best Interests, and the situation really was not an emergency:

"the MCA does not impose impossible demands on those who do acts in connection with the care or treatment of others. It requires no more than what is reasonable, practicable and appropriate. What that entails depends on all the circumstances of the case. As the judge recognised, what is reasonable, practicable and appropriate where there is time to reflect and take measured action may be quite different in an emergency or what is reasonably believed to be an emergency."

39 Essex Chambers | Commissioner of Police for the Metropolis v ZH | 39 Essex Chambers | Barristers' Chambers

Restrictive practice points

- Restraint should reflect the fourth MCA principle, seeking a 'less restrictive option'. Consider if the need for restraint can be removed? e.g. the use of telecare to know if the person leaves a room.
- Restraint should be agreed by relevant professionals using the Best Interests process; in an emergency it may need to be carried out really quickly. If it can be predicted that restraint may be needed as a last resort, it should be planned for, and written in the person's care plan.

- De-escalation techniques and positive behaviour support plans for the person should be in place; their use may avoid the need for restraint.
- Research found that when people's communication needs were met, they were less distressed resulting in fewer incidents and restraints.
- Any use of restraint should be trauma-informed, for example avoiding the use of male staff with women who have been sexually abused.

Northamptonshire Healthcare NHS Foundation Trust has produced a guide to reducing restraint in inpatient mental health settings, also relevant for other settings:

https://www.nhft.nhs.uk/download.cfm?doc=docm93jijm4n13461.pdf&ver=32078

- A proportionate use of restraint might be gently holding someone's arm still if they have tremors to have a Covid-19 or flu vaccination.
- If there is an attorney with the relevant valid powers or a court appointed deputy, staff must not act in conflict with their decision of what is in the person's Best Interests.
- Equally, staff are not stopped by an attorney's or deputy's determination of Best Interests from providing life-saving treatment or doing something to stop a serious deterioration in the person's condition – but then must go to Court to resolve it.
- Always seek legal advice and go to Court if there is a dispute/disagreement.

Out of sight – who cares? Restraint, segregation and seclusion review

https://www.cqc.org.uk/publications/themed-work/rssreview

This CQC report looked at the use of restraint, seclusion, and segregation in adult social care and mental health services for children and adults with a mental health condition, a learning disability, or autistic people. While the CQC did find good practice, they also found very poor practice and human rights abuse risks.

Some of the restraint in the report takes place under Mental Health Act 1983 processes in hospitals. Other community adult social care examples in the report used Mental Capacity Act 2005 processes. There were fewer restrictive practices reported to the CQC in community social care settings. The report acknowledges that there are no national reporting mechanisms for restrictive practice in social care (unlike in mental health), and it is only reported to the CQC when there is also a safeguarding concern.

One of the recommendations made was:

"There must be renewed attempts to reduce restrictive practice by all health and social care providers, commissioners and others. We have seen too many examples of inappropriate restrictions that could have been avoided. We know in absolute emergencies this may be necessary, but we want to be clear – it should not be seen as a way to care for someone".

- If restraint amounts to a deprivation of liberty, it must be properly authorised under the Deprivation of Liberty Safeguards (DoLS) (see below).
- If restraint has become part of regular care planning and is not authorised under DoLS take legal advice and consider authorising by the Count of Protection.

Other use of restraint

Restraint may also be used under common law in circumstances e.g. when there is a risk that the person may harm someone else, or for emergency treatment, if it is necessary and proportionate, until either a Mental Capacity Act or a Mental Health Act assessment is completed

When and how to treat patients who refuse treatment | The BMJ

Covert medication

- Only agree covert medication in exceptional circumstances
- It must be a Best Interests decision process; must involve relevant health professionals, the pharmacist, and family and/or the person's representative
- A formal Best Interests meeting should be convened
- If agreed, make records and management plan including review
- Ensure easily accessible documentation in the adult's records

If there is no agreement, an immediate application to the Court of Protection must be made by the appropriate person, such as the CCG for a GP, or the NHS Foundation Trust for a consultant.

Case about covert medication to control behaviour
https://www.bailii.org/ew/cases/EWCOP/2016/37.html

SCIE and NICE quick guide to giving medicines covertly. July 2019
Home care: Giving medicines covertly support | SCIE

Deprivation of liberty and DoLS

What is a deprivation of liberty?

A person who lacks the relevant mental capacity to make decisions about their care or treatment is deprived of their liberty if, as a result of additional restrictions placed upon them because of their mental disorder, they are:

- not free to leave the accommodation, and
- under continuous supervision and control.

This was determined in the 2014 Supreme Court judgement in the Cheshire West and Chester case and is often referred to as the **'acid test'**.

> "The fact that my living arrangements are comfortable, and indeed make my life as enjoyable as it could possibly be, should make no difference. **A gilded cage is still a cage."**

Since then the Court of Appeal has commented that "not free to leave" means not free to leave that accommodation permanently; that is, someone may be free to go to the shops, join community activities, or go to work or school.

DoLS, the Deprivation of Liberty Safeguards

The Deprivation of Liberty Safeguards (DoLS) is an amendment to the MCA which provides legal protection for people who lack capacity to consent to their care or treatment, and who live in a care home or hospital in circumstances which add up to a deprivation of the person's liberty.

The local authority has the role of authorising a deprivation of liberty in its role as a supervisory body. With the implementation of the Mental Capacity (Amendment) Act 2019, others will also gain the role; further guidance will be issued.

The Court of Protection has wide ranging powers about any question relating to a DoLS authorisation and can change or end an authorisation.

The DoLS Code of Practice supplements the main MCA Code of Practice:
12369 Mental Capacity 18th.indd (cqc.org.uk)

- The DoLS protect people from being deprived of their liberty unless it is in their best interests and there is no less restrictive alternative.
- If arrangements amount to a deprivation of liberty, first consider can they be less restrictive within Best Interests?
- If less restriction is not in the person's Best Interests and a deprivation of liberty is, then an authorised DoLS Best Interests Assessor must be involved.
- The DoLS Best Interests Assessor (BIA) is different to care planning; a BIA completes specific accredited training.
- The BIA must assess and make an application to authorise the deprivation of liberty under DoLS to make it lawful.
- There are six parts to the DoLS assessment, carried out by two people: age, mental health, mental capacity, Best Interests, eligibility, and no refusals.
- A Relevant Person's Representative (RPR) must be appointed to represent the person's views (who may or may not be the IMCA).

People who are subject to a Dols must be informed about their right to appeal.
DoLS Section 21A Appeal | Edge Films (edgetraining.org.uk)
2.56 mins

A DoLS authorisation does not authorise medical treatment, such as a flu jab.

The Association of Directors of Adult Social Services (ADASS) has produced guidance on DoLS: ADASS

Out of sight – who cares? Restraint, segregation and seclusion review
https://www.cqc.org.uk/publications/themed-work/rssreview

The CQC report 'Out of sight' found instances of the use of seclusion, referred to as 'time-out' when people were asked to go to an area such as their bedroom and prevented from leaving. While the reason was to prevent harm, it was likely to be unlawful as there was no DoLS authorisation in place.

The report also found cases where people were locked in their accommodation on their own with no staff, monitored from outside. There was no Best Interests decision making in place nor DoLS authorisation.

Other instances of deprivation of liberty

DoLS does not apply to people under 18, nor to adults outside hospital or care homes. So if any 16- and 17-year-olds are deprived of their liberty in any setting, or adults living in community settings such as supporting living are deprived of their liberty, there must be an application to the Court of Protection for a deprivation of liberty order to authorise it. This is due to change with the implementation of the Mental Capacity (Amendment) Act 2019.

When DoLS does not apply

Government guidance, updated October 2020, based on Ferreira case, April 2020 clarifies that people are not deprived of their liberty if both:

- the restriction or restraint is so that they can be given life-saving care or treatment, and
- that treatment would be the same whether or not the person has capacity to consent to the restrictive arrangements.

The interface between the Mental Capacity Act and the Mental Health Act

The MCA is not the Mental Health Act.

The Mental Health Act 1983 and amended by the Mental Health Act 2007 only covers assessment and appropriate medical treatment for mental disorder or disability; it does not cover other decisions, seclusion or restraint, or medical treatment for physical conditions.

A capacity assessment is not the same as the assessment for detention and treatment under the Mental Health Act 1983. Many people detained under the Mental Health Act have the capacity to make decisions for themselves. On the other hand, most people who lack capacity to make some decisions will never be affected by the Mental Health Act.

But when it comes to a Best Interests assessment using the DoLS, the mental health part of the assessment is about a diagnosable mental illness.

If a person is detained under the MHA section 2 for assessment and /or treatment under MHA section 3, the MCA may be used for other decisions, for example if there is doubt about their capacity to consent to treatment for an unrelated physical health condition such as a broken arm.

39 Essex Chambers produced a table (in 2018) summarising the key differences between the MHA and MCA, which is in this Community Care Inform guide on the Tri.x website:

https://proceduresonline.com/trixcms/media/4395/the-interface-between-the-mental-health-act-1983-and-the-mental-capacity-act-2005-adults.pdf

The Kings Fund carried out research which found that practitioners routinely use whichever Act applies more to their professional role, which can contribute to people being deprived of their liberty unlawfully.

A tale of two Acts: the Mental Health Act, the Mental Capacity Act, and their interface | The King's Fund (kingsfund.org.uk)

SARs for Joanna 'Jon' & Ben

- When they died, Joanna, Jon & Ben were detained under the Mental Health Act at a private hospital.
- In their cases, MCA capacity assessments and subsequent best interests decisions for other matters were not recorded, apart for occasional medication decisions.

Joanna, Jon and Ben - published September 2021 | Norfolk Safeguarding Adults Board

Edge Training summary about the SAR for Joanna Jon & Ben
Deadlier than Winterbourne View? (edgetraining.org.uk) September 2021

And the PDF Deadlier than Winterbourne View.pdf

Making Records

As with all records made under public law, your notes and the case records may become evidence, be used in Court, or be used in a police investigation. Recording must be detailed, accurate, and not just a few bullet points. Record words spoken or behaviours observed, over time. Include your reasons and rationale, why and why not.

If you do not make adequate records, detailing the capacity assessment and then the best interests decision making process, you may not be protected by the MCA and may be acting illegally. You could be liable for damages or criminal prosecution for trespass, assault, fraud and theft, false imprisonment, or battery.

A record kept of the process of working out the best interests of a person for each formal relevant decision should show:

- **What evidence has been gathered?**
- **Who was consulted to help work out best interests?**
- **What particular factors were taken into account?**
- **How was the decision about best interests reached?**
- **Demonstrate how conflicting views assessed**
- **The reasons for reaching the decision – the rationale.**

This record should remain on the person's file

For major decisions it may be useful for family to keep a similar kind of record, in order to avoid future disagreements.

"It is hard to overemphasise the importance of accurate, thorough and contemporaneous recording to agencies being able to give clear and defensible accounts of their decision-making both within and between agencies."

Leeds SAR

Records of Best Interests meetings

Best Interests meetings need to be organised, with people invited as appropriate, minutes circulated, with clear actions identified and a timely review.

How do we know when we've done this correctly?

The BMA/RCP proforma for documenting best interests decisions about Clinically Assisted Nutrition and Hydration (CANH) has space to highlight any areas of disagreement that the court would need to address, which could be useful practice to adopt.

https://www.bma.org.uk/advice-and-support/ethics/adults-who-lack-capacity/clinically-assisted-nutrition-and-hydration

Poor practice – record and decisions

"We have seen records of so-called 'best interests' decisions to fit feeding tubes, or to continue with CANH, which indicate that treatment is in the patient's best interests simply on the grounds (for example) that: "Patient cannot swallow" or "Wife consents"."

Life-sustaining treatment contrary to his best interests: Lessons from a supplementary hearing – Promoting Open Justice in the Court of Protection (openjusticecourtofprotection.org)

Court of Protection case examples

Judgement about what is in the best interests of an 84-year-old woman with Alzheimer's Disease in terms of her residence, care and support, and contact with her children

DA v EP & Ors (COP- Deprivation of Liberty/Welfare) [2020] EWCOP 74 - Court of Protection Hub

Failing to comply with MCA, DoLS and poor evidence recording by CCG and NHS Trust. [2019] EWCOP 58, Case report Feb 2020

https://www.courtofprotectionhub.uk/cases/a-fact-finding-2019-ewcop-58

The Mental Capacity Act and safeguarding adults, what good looks like. Practice guides in this series

1. What is capacity, the MCA, who uses it? The Court of Protection
2. Capacity assessment process
3. Challenges in capacity assessment e.g. fluctuating capacity, reluctance to engage
4. Preferred communication (for all practicable support)
5. Top tips, with a working example of safeguarding when capacity is a feature
6. Assessment form sample and expected standards
7. Next of Kin, Living Wills, Attorneys, Deputies, and the role of the Office of the Public Guardian
8. Best Interests decision making process (this one)

More MCA resources

The Mental Capacity Act 2005

39 Essex Chambers | Mental Capacity Guidance Note Determining and Recording Best Interests - July 2020 | 39 Essex Chambers | Barristers' Chambers

The Toolkit - Mental Capacity Toolkit

Mental Capacity Law and Policy

Mental Capacity Act - NHS (www.nhs.uk)