How to apply Deprivation of Liberty Safeguards

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Keywords: Deprivation of liberty/Capacity/Mental Capacity Act

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2. Deprivation of Liberty Safeguards (DoLS) can only apply to individuals who are assessed as lacking capacity
3. Capacity is decision specific – the level of capacity must be judged based on the decision being made
4. Any deprivation must be proportionate
5. Interventions performed under the umbrella of DoLS must be in the patient’s best interest

Most nurses will be familiar with patients refusing care and treatment, or refusing to remain in hospital against the advice of health professionals. However, they may not know exactly what they, or other members of the multidisciplinary team, can do in these situations. The Deprivation of Liberty Safeguards (DoLS) offer guidance on this; the clarity this gives protects patients and the health professionals working with them. The DoLS are part of the Mental Capacity Act 2005 and apply only to patients who lack capacity.

Patients with capacity

Before considering patients who lack capacity it is important to be clear of the rights of those with capacity. This is guaranteed in English law, stated by Lord Donaldson in the case Re T [1992] All ER 649 (tinyurl.com/ReT-1992):

“An adult patient who, like Miss T, suffers from no mental incapacity has an absolute right to choose whether to consent to medical treatment, to refuse it or to choose one rather than another of the treatments being offered ... This right of choice is not limited to decisions which others might regard as sensible. It exists notwithstanding that the reasons for making the choice are rational, irrational, unknown or even non-existent.”

Lord Donaldson MR [102]

This position has been confirmed in many court decisions since; two that clearly illustrate the absolute nature of this right are St Georges Healthcare NHS Trust v S, R v Collins, ex p S [1998] 3 WLR 936 and Re B (adult: refusal of medical treatment) [2002] EWHC 429 (fam).

In the first of these cases, S was diagnosed with severe pre-eclampsia 36 weeks into her pregnancy and was advised she needed to be admitted to hospital for treatment. She understood the risks of declining treatment but repeatedly expressed the wish for her child to be born naturally. It was identified that she had previously been diagnosed with moderate depression and that the relationship with the baby’s father had recently ended.

S was seen by an approved social worker and two doctors; having declined their advice she was compulsorily admitted to a psychiatric ward for assessment under Section 2 of the Mental Health Act 1983. The...
grounds for the admission were that S was “suffering from mental disorder of a nature or degree that warrants detention... with a view to the protection of other persons”. The court identified that “other persons” could only have been the foetus. Under the Mental Health Act, S underwent a Caesarean section and discharged herself once the section was lifted. She appealed the grounds for her detention and treatment.

In a lengthy judgment the Court of Appeal considered the issues raised, and made clear the right of the pregnant woman to refuse treatment, even when this placed the life of her unborn child at risk:

“In our judgement while pregnancy increases the personal responsibilities of a woman, it does not diminish her entitlement to decide whether or not to undergo medical treatment. Although human, and protected by the law in a number of different ways... an unborn child is not a separate person from its mother. Its need for medical assistance does not prevail over her rights. She is entitled not to be forced to submit to an invasion of her body against her will, whether her own life or that of her unborn child depends on it. Her right is not reduced or diminished merely because her decision to exercise it may appear morally repugnant.” [at 957; St Georges Healthcare NHS Trust v S, R v Collins, ex p S [1998] 3 WLR 936]

The ultimate right – that of a competent patient to decide on withdrawal of treatment that would lead to their death – was confirmed in the case Re B (adult: refusal of medical treatment) [2002] WHC 429 (fam). This case concerned a patient, Ms B, who, following a bleed in her upper spinal column, was paralysed from the neck down and became dependent on artificial ventilation. MS B had refused this treatment but was judged to lack capacity by two psychiatrists in April 2001 and her request for ventilation to be withdrawn was rejected. However, following assessment by an independent psychiatrist in August of that year, she was determined to have capacity. Ms B again requested discontinuation of ventilation; her doctors again refused, despite there being an acceptance of her competence. In her ruling, Butler-Sloss stated: “Unless the gravity of the illness has affected the patient’s capacity, a seriously disabled patient has the same rights as the fit person to respect for personal autonomy... I am... satisfied that Ms B is competent to make all relevant decisions about her medical treatment including the decision whether to seek to withdraw from artificial ventilation. Her mental condition is commensurate with the gravity of the decision she may wish to make...” [at 94-95; Re B (adult: refusal of medical treatment) [2002] WHC 429 (fam)]

Even if a nurse believes a patient’s decision is unwise and not in the patient’s best interests, the patient has the right to make that decision. The responsibility of clinical staff is to establish whether patients have capacity and fully understand the possible implications of their decisions, and to ensure this is documented.

### Mental Capacity Act 2005

DoLS form part of the Mental Capacity Act 2005, which sets out the rights of patients who lack capacity. It is underpinned by five principles (Box 1), which must inform each and every decision a nurse or doctor makes about a patient, be it whether to have a wash or be discharged.

#### The Bournwood Gap

To understand why DoLS provide a safeguard it is useful to examine how they came about. What came to be known as the Bournwood Gap was identified with the case HL v UK [2004] (English, 2004). This concerned an individual, HL, who had been living with paid carers for a number of years. HL was 48 years old, and had autism and profound learning difficulties.

While attending a day centre attached to Bournwood Hospital in July 1997, HL became distressed and was informally admitted as an inpatient. The nature of his disabilities were such that he did not make any attempt to leave the hospital but it was noted that he became distressed when his carers, who wished to take him home, visited him. This resulted in the hospital preventing the carers from visiting. The carers went to court to obtain HL’s release; initially the domestic courts rejected the request stating that, as he did not try to leave the hospital, HL was not being restrained and the informal admission was legitimate.

HL was discharged back into the care of his carers in December 1997 after five months as an informal inpatient. However, the case was taken to the European Court of Human Rights, which took the view that such detention breached HL’s rights under Article 5(4) of the Human Rights Act 1998 – the right to liberty and security. The court instructed the UK to rectify this gap in provision, whereby an individual who lacked capacity but was not detained under the Mental Health Act 1983 could be detained. This is known as the Bournwood Gap.

DoLS became part of UK law in 2007 and came into effect in 2009. Jackson (2010) highlights that the difference between restricting individuals’ freedom and depriving them of their liberty may be “a question of degree”. It is this question that can be challenging for health staff.

The DoLS Code of Practice (2008) identifies factors that may be relevant in identifying whether steps taken by the health or social care team amount to deprivation of liberty. The list is not exhaustive but the following may be relevant in general ward settings. Liberty may be deprived if:

- Staff exercise complete and effective control over the care and movement of the person for a significant period;
- Staff exercise control over assessments, treatment, contacts and residence;
- A request by the carers for the person to be discharged to their care is refused;
- The person loses autonomy because they are under continuous supervision and control.

#### Determination of capacity

When considering whether a person is being deprived of their liberty, health workers must first determine whether the person lacks capacity in respect of the decision being taken. Capacity determination is covered by Section 3 of the Mental Capacity Act 2005: capacity should be presumed unless there is evidence to the contrary.

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**Box 1. MENTAL CAPACITY ACT 2005: UNDERPINNING PRINCIPLES**

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

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If staff believe a patient lacks capacity a clear test is set out in law. This starts with the “trigger test”: is there reason to believe the person has a condition that impairs capacity, for example dementia, infection, brain injury? If the answer is “yes”, there follows a four-stage test of capacity:
1. Does the individual understand the information being presented?
2. Can they retain the information?
3. Can they weigh up the information?
4. Can they communicate a decision?

The capacity test can be undertaken by any health or social care team member who understands the decision being made. It is important to understand that capacity is decision specific and the degree of capacity should be proportionate to the decision being made – for example, while a person can make a decision about which clothes to wear, they may not have the capacity to take a decision on invasive investigation.

Assessment of capacity is not always straightforward but the test does provide clear guidance on the areas to be considered. If a health professional has extended periods of contact with the patient, the test will often come from routine contact but it is vital the formal examination is clearly documented.

How does this work on the ward?
The behaviours that may lead nurses to consider whether DoLS is appropriate include:
- Attempting to leave the ward;
- Striking out at staff providing care and treatment;
- Repeatedly stating a wish to leave the ward, even if lacking the physical ability;
- Repeated removal of medical devices such as nasogastric tubes or cannulas.

DoLS should also be considered if the above behaviours are being managed with sedating medications.

In many ways DoLS is a bureaucratic procedure but for a ward-based nurse who thinks a patient’s liberty is being restricted, it is essential. Trusts may take varying approaches to DoLS applications but, no matter what mechanism is in place, it is essential the application for both urgent and standard DoLS authorisation is made.

Urgent DoLS refers to an appropriately trained individual assessing that it is in the patient’s best interests. As the deprivation has been documented, the nurse authorising the use of a deprivation should not be considered to be at fault.

On completion of the assessment, the external assessor may then determine that the deprivation is not appropriate and not in the patient’s best interests. As the appropriate procedures and protocols have been followed, and rationale for deprivation has been documented, the nurse should not be considered to be at fault.

The need for DoLS assessment may be obvious but it can also be unclear, as illustrated by the fictional scenarios in Box 2.

**Conclusion**
Patients who have full capacity are free to make their own decisions, even if these appear to health professionals to be poor. If patients do lack capacity, health professionals should consider whether their liberty is being restricted and, if it is, make an application under DoLS. If there is any doubt, consult the person responsible for DoLS in the trust. Most importantly, ensure all decisions are fully documented.

Properly applied, DoLS safeguard staff and patients; they are therefore far more than “just another piece of paper”.

**References**