Deprivation of liberty in intensive care

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Most patients in intensive care units lack mental capacity to inform decision-making, whether because of drugs or disease. The introduction of the Mental Capacity Act in England and Wales in 2005 has changed the way that doctors and institutions deal with patients who lack capacity. This is especially true when physical, mechanical or pharmacological restraints are used to allow the patient's treatment. Recently, the Supreme Court has ruled that if a person is under continuous supervision and control, and is not free to leave the place they are being treated, then they are deprived of their liberty. This article explains the ramification of this ruling for patients in intensive care whose care must now meet Deprivation of Liberties Standards. The procedures both for staff caring for these patients and for the Trusts where they are receiving care are described.

Keywords: *legislation, medical; Mental Capacity Act; Deprivation of Liberties Standards*

The majority of patients in intensive care units lack the mental capacity to make material decisions during a large proportion of their stay, due to drugs or disease. The use of patient restraints (physical, mechanical or pharmacological) is commonly deployed, under the auspices of relevant legislation, to facilitate safe intensive care. Recent developments have led to uncertainty in many clinical settings including intensive care regarding the lawfulness of these practices. The Law Commission is launching a review of the law relating to the deprivation of liberty of those without capacity, which may in due course shed light upon the area, but not for several years. In the meantime, this document aims to provide guidance until current law is more clearly defined or amended.

Background: The legal journey

2005 – The Mental Capacity Act

The Mental Capacity Act 2005 (MCA)[1] was enacted in England and Wales to empower adults who lack capacity to make decisions for themselves.[2] It allows medical treatment to be used, including physical or pharmacological restraint, as long as it is judged to be in the patient's best interests and it meets certain additional criteria reflecting the need for proportionality in the extent of the intervention. The MCA stipulates that before any actions or decisions are taken on behalf of a person who lacks capacity, acting in their best interests, consideration should be given to whether there is a less restrictive alternative.[1] The MCA draws a clear line between restraint and deprivation of a person's liberty.

If a person is restrained, again in their best interests, this must be reasonably believed to be necessary to prevent harm to the person and must be proportionate to the likelihood and seriousness of that harm (MCA s5,6).

If a person who lacks capacity to consent to this is deprived of their liberty, this can only be lawful using the Deprivation of Liberty Safeguards or an Order of the Court of Protection, or where the deprivation of liberty is necessary to give life-sustaining treatment or to do a vital act, while an Order of the Court is sought. (MCA s4A, 4B)

2009 – Deprivation of Liberty Safeguards

The Deprivation of Liberty Safeguards (DoLS) were added to the Mental Capacity Act by amendments made by the Mental Health Act (MHA) 2007.[3] The safeguards were introduced in response to a judgment from the European Court of Human Rights (ECtHR) (*HL v the United Kingdom 2004*), commonly referred to as the Bournewood judgment.[4] The ECtHR ruled that an autistic man with a severe learning disability was unlawfully deprived of his liberty following admission to a psychiatric hospital. HL had initially been admitted informally under common law – ie, without using the MHA – but was then prevented from leaving the hospital. He was sedated in hospital and kept under continuous observation by nursing staff. His foster family was not allowed to see him or to take him home. Although he did not object to being kept in hospital and never tried to leave, the ECtHR found that he was subject to complete and effective control over his care and movements by healthcare professionals and that he was not free to leave.[5] The Court found this to have breached his right to liberty under Article 5(1) of the European Convention on Human Rights (ECHR). Due to the informality of the procedures used to detain HL (especially compared to the procedural safeguards offered by the Mental Health Act 1983), the ECtHR also found that he had no effective right to challenge his detention before a court, and that his rights under Article 5(4) ECHR were therefore also breached.[6]

The DoLS scheme was introduced in response. Its aim was to provide protection for the human rights of vulnerable people who lack capacity to decide about their care and

treatment, where the arrangements made for such care or treatment in hospitals or care homes may amount to a deprivation of their liberty. The safeguards came into force in April 2009, and allow, in essence, the 'administrative' authorisation of a deprivation of a person's liberty. They created a framework within which an organisation must work when it is deemed necessary to deprive a person of their liberty. They also provide a number of protections, including independent scrutiny and the appointment of a representative to act on a person's behalf. They also provide the patient or their representative the right to challenge the decision to deprive the patient of their liberty in the Court of Protection and the right for the decision to be reviewed on a regular basis.[7]

If DoLS cannot be used, a deprivation of liberty can only be authorised by the Court of Protection.

In outline, the DoLS scheme is 'administrative' because it provides a system by which a care home or hospital (a 'managing authority') can refer cases of suspected deprivation of liberty to the relevant local authority (as a 'supervisory body') to carry out independent assessments, which may lead to the grant of a DoLS authorisation for a period of up to a year without involvement of the Court.

2014 – What has changed?

The current uncertainty arises from a Supreme Court ruling on 19 March 2014 usually known as 'Cheshire West' (*P v Cheshire West and Chester Council and P&Q v Surrey County Council 2014*)[7] about the meaning of a 'deprivation of liberty' in the context of the provision of care and treatment to those unable to consent to their accommodation arrangements.

These two cases, heard together by the Supreme Court, involved three people with significant learning disabilities who required varying levels of restraint to facilitate care in a community setting.

P and Q (also known as MIG and MEG) were sisters with learning disabilities who were cared for in foster accommodation and a residential home respectively. MIG never attempted to leave the foster home by herself but would have been prevented from doing so had she tried. MEG had more complex needs and sometimes required physical or chemical restraint. In 2009, a Court of Protection judge found that these living arrangements were in the best interests of MIG and MEG and did not amount to a deprivation of liberty, so the additional independent scrutiny and regular reviews required to authorise such a deprivation were not triggered. The Court of Appeal[6] upheld this conclusion.

The other case was of P, a gentleman with cerebral palsy and Down's syndrome who required intervention on occasion due to his challenging behaviour. A Court of Protection judge found that the interventions used *did* represent a deprivation of liberty but that it was in P's best interests for them to continue. The Court of Appeal overturned the finding that P had been deprived of his liberty, largely based on a comparison between his circumstances and those of another individual of similar age and disability, holding that there would not typically be a deprivation of liberty where the care was relatively normal for someone with those needs.[6]

In 2014, the Supreme Court overturned both Court of Appeal decisions[7] and found that MIG, MEG and P had all been deprived of their liberty. Importantly, the judgment of the majority identified an 'acid test' for deprivation of liberty, namely that if a person is under continuous supervision and control and is not free to leave, then this constitutes an objective deprivation of their liberty. If the person is unable to consent to the deprivation of liberty, then (and if it is also 'imputable to the State' which will be the case in all hospitals), an authorisation will be required under the DoLS regime or from the Court of Protection if the deprivation of liberty is to be lawful.

Deprivation of liberty: Who, what, when and why to consider it in intensive care

Who is at risk of being unlawfully deprived of their liberty?

The DoLS regime applies to hospitals, although the conventional understanding of the legislation was that applications for DoLS authorisations should not be made where a patient would cease to be deprived of their liberty within seven days. This meant that applications had not been made routinely in the intensive (as opposed to chronic) care setting.

The acid test framed by the Supreme Court was not decided in the intensive care setting. However, the concept of a deprivation of liberty is not context-specific, so is capable in principle of applying in this setting. Due to their circumstances, most patients in intensive care units would seemingly fit the 'acid test' criteria, and it could therefore be construed that we are depriving them of their liberty. This is supported by a recent case[8] (published 28 August 2014), in which a judge applied the Cheshire West acid test to a maternity unit in a general hospital.

Despite this there are some exclusions where patients are *not* considered to be deprived of their liberty, namely those who:

- have the capacity to decide to be admitted to *intensive* care
- consent to the restrictions applied to them
- gave consent for intensive care admission prior to losing capacity – for instance prior to surgery (though they must have had an understanding that they may be under continuous supervision and control and not free to leave at some time within their stay).

Note also that patients detained under the Mental Health Act 1983 will be considered differently, as detention under that Act constitutes authorisation of any deprivation of liberty to which they are subjected.

Current MCA DoLS legislation refers only to patients in England and Wales. The position in Scotland is different, although it is expected that legislation will be introduced there in due course, equivalent to the DoLS regime.

Why may it be appropriate to deprive a patient of their liberty?

The MCA DoLS code of practice[3] highlights that deprivation of liberty is justifiable, where the person lacks capacity to consent to this:

- if it is in their best interests to protect them from harm
- if it is a proportional response when compared with the

potential harm faced by the person
- if there is no less restrictive alternative.

What actions constitute deprivation of liberty?

Although the Supreme Court has made the position very much clearer by the framing of the acid test, it is important to note that there is still no statutory definition of a deprivation of liberty.

The Mental Capacity Act simply defines deprivation ofliberty' by reference to the ECtHR case law, and it is this case law which is distilled by the Supreme Court in the Cheshire West case. However, other guidance, such as the DoLS Code of Practice is still relevant and helpful, though it must be read in light of the Supreme Court judgment.

It is useful to consider restrictions imposed upon a person's activities as a scale ranging from minimal restriction at one extreme to deprivation of liberty at the other. Furthermore, the ECtHR has stipulated that deprivation of liberty depends on the specifics of each individual case.

In many cases in intensive care, it will be possible to identify relatively easily that the acid test is satisfied. However, it is important to note that other factors may be relevant to the assessment of the extent to which continuous supervision and control is being exercised, including, in particular:
- the use of restraint to bring about admission
- the use of restraint/medication being used forcibly against the patient's will during the course of the admission
- staff taking decisions on a person's behalf regarding treatments and contact with visitors[9]
- duration of the restrictions.

Crucially, the Supreme Court in Cheshire West made it clear that in all cases, the following principles are *not* relevant when considering whether deprivation of liberty is occurring:
- the reason for treatment
- compliance with treatment
- lack of objection
- family/carer's agreement
- appropriateness or 'normality' of the treatment
- lack of an alternative safe place for treatment.

Note that it would appear that focus in deciding whether a patient is 'free to leave' should not be on whether the patient is actually physically capable of leaving, but rather upon what actions hospital staff would take if – for instance – family members sought to remove them.

At what point does deprivation of liberty begin?

A deprivation of liberty must last more than a 'non-negligible' period of time. There is no fixed definition of how long a period of time is required. However the following principles should be considered:
- Though it has not yet been tested in the Courts, it would appear unlikely that a court would find that the acid test for deprivation of liberty means that someone is unlawfully deprived of their liberty by the provision of life-sustaining treatment in a true emergency situation.
- In all cases, life-sustaining interventions or the provision of emergency care should be given as clinically required and never delayed for prior deprivation of liberty authorisation to be sought (see MCA s4B).
- However, you should bear in mind that MCA s4B allows a deprivation of liberty where necessary to provide life-sustaining treatment or perform a 'vital act' (which is reasonably believed to be necessary to prevent a serious deterioration in the person's condition) "while a decision as respects any relevant issue is sought from the Court."
- Although there is no clear period of time after which a patient in intensive care would be considered to be deprived of their liberty, and therefore an application to Court is required if the DoLS cannot be used, the risk of a deprivation of liberty increases with increasing duration of treatment and when initial emergency treatment transitions to ongoing care. Such transition points must be considered on an individual patient basis and will be context dependent.
- Deprivation of liberty exists on a spectrum of levels of intervention and control over someone's life, with the duration of the intervention being only one of many factors. In some cases, very extreme degrees of intervention have been held to be a deprivation of liberty even though they only lasted for a few minutes.
- Deprivation of liberty should be considered separately from medically treating a patient in their best interests. The pre-existing justifications used for treating patients who lack the capacity to consent still apply. Consider this example:

A patient (P) is admitted to the intensive care unit following a cardiac arrest. There is a high clinical index of suspicion of hypoxic brain injury. P should be treated without delay according to clinical needs. After a few days of treatment, it is clear that P has suffered major hypoxic brain injury and is likely to require treatment in hospital for considerable time. He is under continuous supervision and control and is not free to leave and, being unconscious, does not have mental capacity to consent to his care. At this point, it can be argued that P satisfies the criteria set out by the acid test. Treatment must continue in exactly the same way based on P's clinical needs. However, in addition, there would be a request for DoLS authorisation for P to meet the Article 5 rights to due process and independent scrutiny where he is deprived of liberty.

Deprivation of liberty authorisation

What is a DoLS authorisation?

A DoLS authorisation allows lawful deprivation of liberty. It does not, in itself, authorise specific treatments or procedures. Any treatments required for a patient who lacks capacity must therefore be provided under the 'best interests' provision of the Mental Capacity Act[7] (and with appropriate regard to whether the patient has made any relevant advance decision to refuse such treatment).

There are two forms of DoLS authorisations. Standard authorisations are ideally applied for in advance of a person requiring deprivation of their liberty. They are granted by the supervisory body (usually the local authority where a person resides) within 21 days of application. Urgent authorisations can be made by the managing authority itself (ie, the manager responsible for the hospital/care home within which the deprivation of liberty will occur). Urgent authorisations can only be made where a standard authorisation has been applied

for but is not yet granted. As such, an urgent authorisation can never be made without a simultaneous application for a standard authorisation.[7] Urgent authorisations last for a maximum of seven days but in exceptional circumstances the supervisory body can extend this for an additional seven days. If necessary, it can be granted by the on-call manager of a Trust.

Within intensive care it is likely that all DoLS authorisations will be made as urgent authorisations in the first instance.

Once in place, a DoLS authorisation ensures that the supervisory body will appoint a representative for the patient, regularly review whether ongoing deprivation of liberty is required and remove the authorisation when it is no longer necessary.

DoLS authorisations are not transferrable between institutions and are subject to regular review. A review can occur at any time and may be triggered by the patient, their appointed representative or an independent mental capacity advocate (IMCA) for the patient. This usually occurs when a person's circumstances change. The maximum duration a standard authorisation can be in place is 12 months.

What does the assessment process involve?

There are six assessments made to authorise deprivation of liberty under DoLS:

1. Age assessment: Is the person over 18 years of age?
2. Mental health assessment: Is the person suffering from a mental disorder? This can include acute confusion, delirium or drug-induced disorder of cognition.
3. Mental capacity assessment: Does the person lack capacity to consent to admission for care and treatment?
4. Eligibility assessment: is (or should) the person be subject to treatment under the MHA 1983? (note that such a patient may still be eligible to be deprived of their liberty under the DoLS regime in a general hospital for purposes of receiving treatment for their physical disorders).
5. 'No refusals' assessment: has the person refused treatment or made a relevant advance decision or will the authorisation conflict with valid decisions made on a person's behalf by a lasting power of attorney *or* a court appointed deputy?
6. Best interests assessment: is the deprivation of liberty required and is it in the person's best interests?

The person must meet the criteria of all six assessments to allow a DoLS authorisation to occur.

Why may a DoLS authorisation be refused?

There are multiple reasons why a DoLS authorisation may be rejected by the supervisory body.[3] This will usually be because:

- there is a less restrictive way to provide safe care for the patient
- a deprivation of liberty is not deemed to be in the patient's best interests
- the patient requires detention under the Mental Health Act 1983

  or
- the decision to deprive a patient of their liberty is refused or objected to by an attorney appointed by the patient when they had capacity or a deputy appointed by the Court of Protection to act on the patient's behalf.

Summary of recommendations:

For the lead clinician

1. Emergency treatment and clinical care should be the first priority. The legal implications of deprivation of liberty are not optional but should not hinder or delay provision of essential clinical care .
2. Every patient admitted to intensive care should be considered at risk of deprivation of liberty. All patients should be regularly assessed for mental capacity and whether they are being deprived of their liberty. This assessment should be written in the case notes.
3. A relevant change in the patient's circumstances, including a material change in their duration of stay, should trigger a repeat assessment of deprivation of liberty. Bear in mind that the duration of the intensive care unit stay should not be seen in isolation from the time that the patient may spend as an inpatient overall.
4. Patient compliance and/or family agreements are not relevant to whether a situation represents deprivation of liberty.
5. Every effort should be made to prevent deprivation of liberty where possible and to use the 'least restrictive' alternative available to facilitate safe treatment/care.
6. Patients whom are deprived of their liberty should be referred for an urgent DOLS authorisation from the managing authority within the hospital Trust at the earliest safe time.
7. A DoLS authorisation does not, in itself, authorise specific treatments. Treatment provided for patients who lack capacity should be undertaken under the 'best interests' provisions of the Mental Capacity Act (and taking into account whether any relevant advance decisions have been made refusing the proposed treatment).
8. A DoLS authorisation should be regularly reviewed, and amended (in the case of a change of circumstances) or revoked when required.
9. Where a DoLS authorisation is refused, the clinicians involved in the patient's care must ensure that deprivation of the patient's liberty does not occur. Unlawful deprivation of liberty exposes the Trust to potential liabilities and is a breach of the patient's human rights.
10. All deaths of patients which occur where a DoLS authorisation is in place should be reported to the coroner.[3]

For the Trust

1. Every Trust should have an agreed DoL policy to ensure compliance with the assessment process. Intensive care representation should be sought to achieve this.
2. All patients who are deprived of their liberty should be assessed for an urgent DoLS authorisation as soon as feasibly possible.
3. Urgent DoLS authorisations should only be made in parallel with a request for a standard authorisation from the supervisory body.
4. Ensure that appropriate procedures and support are in place to allow review of DoLS authorisations.
5. All DoLS notifications and authorisation requests should be

appropriately recorded and scrutinised at Trust level.
6. Legal advice should be sought promptly where there is any doubt as to whether a case falls within the Trust's DoL policy.
7. Ensure that there is appropriate provision of ongoing training, and regular review of policies and procedures, as the case law in this area is moving fast.

Declaration

This article is based on the work performed at a colloquium organised jointly by the ICS and FICM

Conflicts of interest

None declared.

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