



Mental Capacity Act 2005 & Deprivation of Liberty Safeguards (DoLS) 2009 session

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Age?



- In England and Wales the age for mental capacity is 16 years of age.
- If your patient is 16 year of age and you have a doubt of capacity, you must use the mental capacity act.
- The patient's parents or guardian are not a decision maker.
- NOK does not allow you to act in the patient's decision maker.

Do you require consent?



Yes;

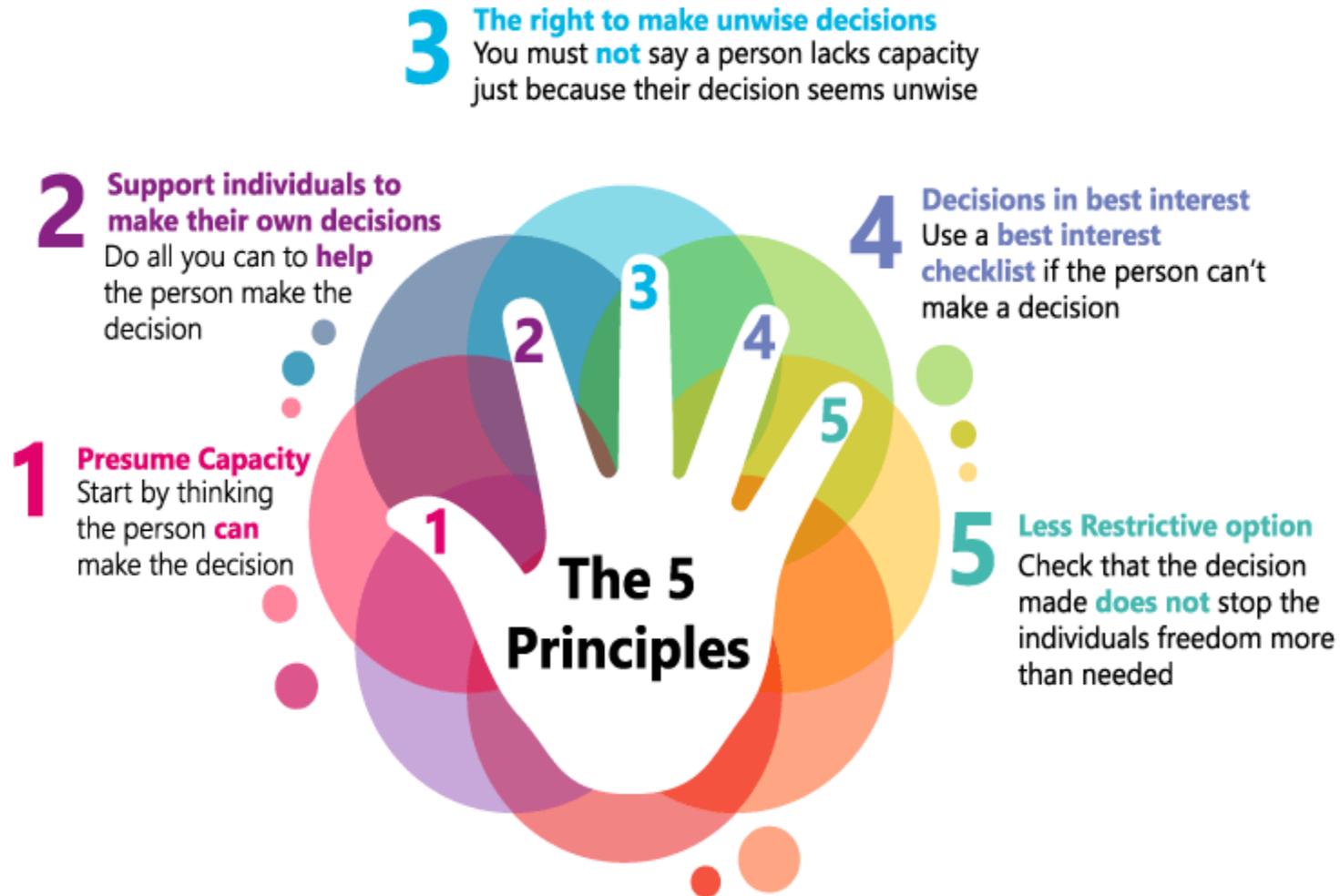
However, there are times when consent can be overridden in these circumstances:

- Recording a mental capacity assessment
- Control or coercion
- Public interest

5 Principles of the MCA



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What is executive functioning

“ability to think, act and solve problems, including the functions of the brain that help us learn new information, remember and retrieve the information we’ve learnt in the past to help us problem solve with everyday life”.

Challenges:

When a patient appears to be coherent to answer questions, but it is clear from their actions that they are not able to put into the effect their intentions.

“The patient is able to talk the talk but not walk the walk”

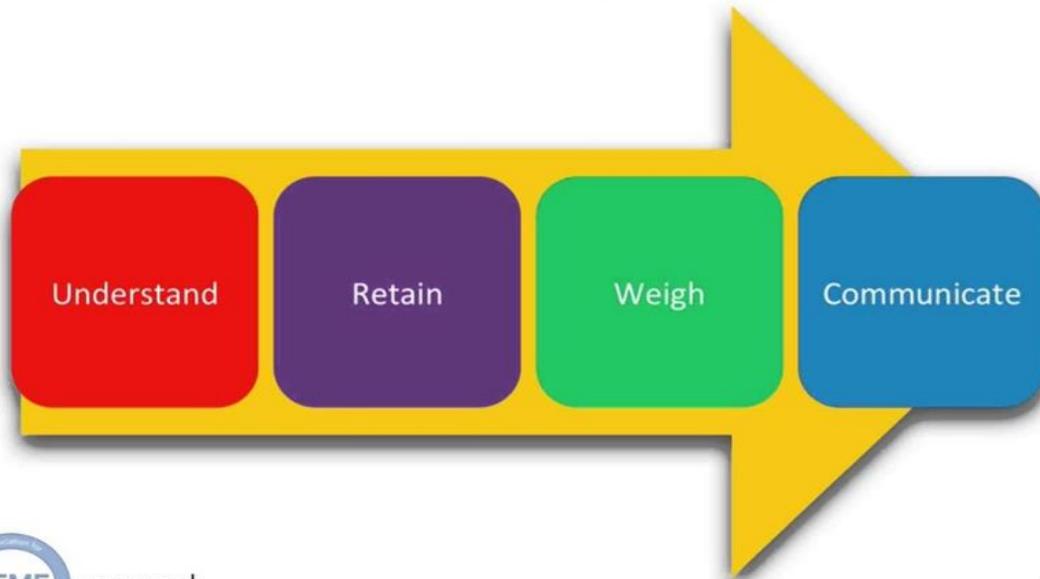
Resource:

[Executive functioning and the Mental Capacity Act 2005: points for practice - Community Care](#)

2 Stage Test



The Mental Capacity Act



The two stage test of capacity

1. Is there an **impairment** of, or disturbance in, the functioning of the person's mind or brain?
2. If so, is the impairment or disturbance **sufficient** that the person **lacks capacity** to make that particular decision?

This 2-stage test must be used and your records should show it has been used

Taken from Mental Capacity Act Code of Practice, section 4.11 – 4.13

Best Interest Decisions



1. Not make assumptions on the basis of age, appearance, condition or behavior.
2. Consider all the relevant circumstances.
3. Consider whether or when the person will regain capacity to make the decision.
4. Support the person's participation in any acts or decisions made for them.
5. Not make a decision about life-sustaining treatment "motivated by a desire to bring about his (or her) death".
6. Consider the person's expressed wishes and feelings, beliefs and values.
7. Take into account the views of others with an interest in the person's welfare, their carers and those appointed to act on their behalf. e.g. Independent Mental Capacity Advocate



Mental Capacity Act 2005

Section 5 – Acts in Connection with Care & Treatment

- Protects staff from liability when providing care or treatment to someone who lacks capacity.
- Actions must be:
 - ✓ In the person's best interests.
 - ✓ A reasonable action that someone with capacity would likely consent to.
 - ✓ The least restrictive option.
- **Key Point:** Section 5 does *not* permit the use of force or restraint.



Mental Capacity Act 2005

Section 6 – Use of Force & Restraint

- Allows the use of restraint **only when necessary** to prevent harm.
- **Key considerations:**
 - ◆ Must be in the person's best interests.
 - ◆ Restraint must be proportionate to the risk of harm.
 - ◆ Must be the least restrictive option.
- **Key Point:** Section 6 does *not* allow deprivation of liberty (e.g., prolonged restraint or detention without legal authorisation).

Lasting Power of Attorney (LPA)




Office of the
Public Guardian

Helpline
0300 456 0300

**Lasting power of attorney for
health and welfare**

Section 1
The donor

You are appointing other people to make decisions on your behalf.
You are 'the donor'.

Restrictions - you must be at least 18 years old and be able to understand
and make decisions for yourself (called 'mental capacity').

Title First names
Mrs Ann

Last name
Other

Any other names you're known by (optional - e.g. a nickname)
N/A

Date of birth
03 03 1947
Day Month Year

Address
150 First Line Road
Town
County
Postcode PO12 3RT

Email address (optional)
N/A@N/A.com

For OPG office use only

LPA registration date OPG reference number
15 01 2016 1000-0000-0001
Day Month Year

Only valid with the official stamp here

Help?
For help with this section, see the Guide, part A1.
If you are filling this in for a friend or relative and they can't complete some decisions independently, they can't make an LPA. See the Guide 'Before you start' for more information.

ADRT



- An advance decision to refuse treatment is a decision made by an adult who is 18 years of age or more, and who has capacity, to refuse particular treatment in advance should they lack capacity to make a decision about it in the future.
- It is not possible to demand a particular treatment. An advance decision only permits the refusal of the treatment specified. A valid, applicable refusal is binding on medical staff.
- Many people with progressive or life-limiting illnesses fear losing control and not being able to tell health professionals their decisions. Under an ADRT, a person can also refuse life-sustaining treatments, including CPR (cardiopulmonary resuscitation), which allows them to die with dignity on their own terms. This gives them peace of mind and helps professionals to focus on delivering the right care and support.

Deprivation of Liberty Safeguards (DoLS)



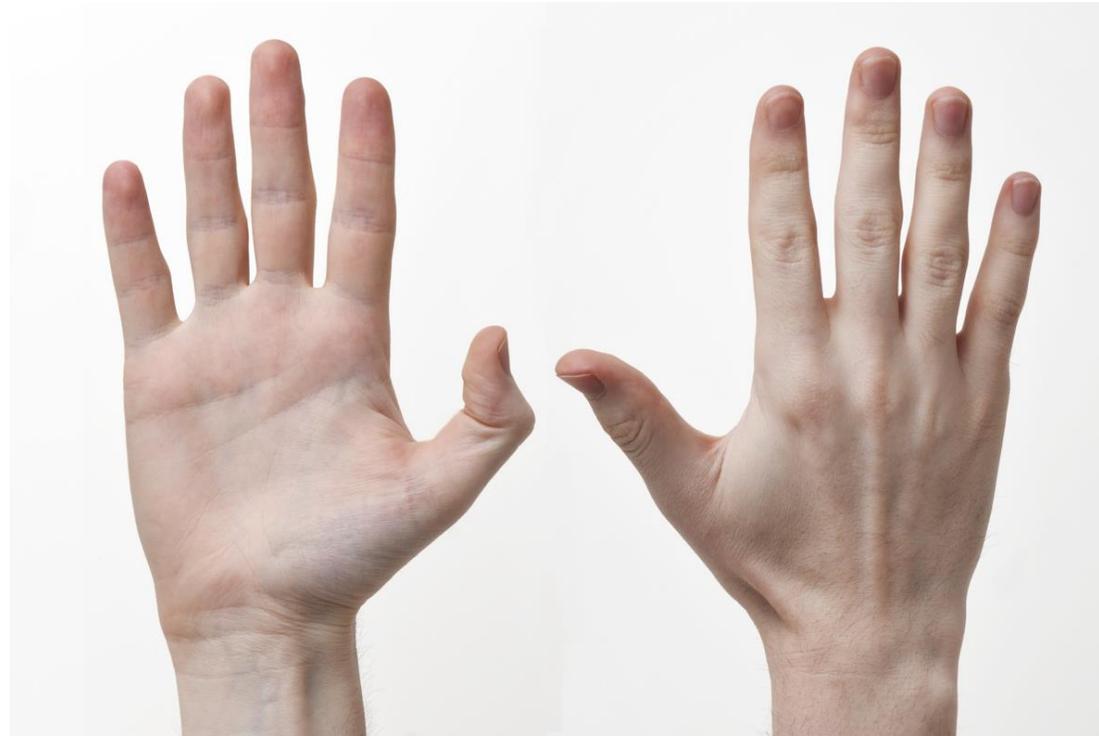
The Deprivation of Liberty Safeguards (DoLS) legal framework is designed to protect rights, if the care or treatment the adult receives in a hospital or care home means they are, or may become, deprived of their liberty, and they lack mental capacity to consent to these arrangements.

The adult can only be deprived of their liberty where it is shown to be in their 'best interests' to protect them from harm, a proportionate response to the likelihood and seriousness of that harm and there is no less restrictive alternative available.

<https://www.youtube.com/watch?v=pz5Ecovjs4w>



Mental
Capacity Act
2005



Mental Health
Act 1983



Case Study 1

- *An elderly patient with dementia is found wandering in a confused state. They have a suspected infection and need hospital treatment but are refusing to go. What steps can you take under the MCA?*
- **Discussion Points:**
 - ◆ How do you assess capacity?
 - ◆ Can you act under Section 5 or 6?
 - ◆ What is the least restrictive option?



Case Study 2

- *A young man with a learning disability is in distress and refuses essential treatment for a severe asthma attack. His family insists he lacks capacity, but he is verbally refusing assistance. What should you consider?*
- **Discussion Points:**
 - ◆ How do you determine if he has capacity?
 - ◆ Can you provide treatment under Section 5 or 6?
 - ◆ What are the ethical considerations?



Case Study 3: Assessing Capacity in an 18-Year-Old with an Eating Disorder

📄 Patient Overview

Age: 18

Living Situation: Resides at home with parents

Presenting Condition: Severe anorexia nervosa

BMI: 13 (indicative of life-threatening malnutrition)

Current Need: Urgent hospital admission for medical stabilization and psychiatric care

🚑 Scene Description

Ambulance crew arrives at the family home following a GP referral for emergency hospital admission due to dangerously low BMI and signs of physical deterioration (e.g., bradycardia, hypotension, fatigue). The patient is alert but reluctant to engage, expressing resistance to hospital treatment.

Parents are visibly distressed and report escalating concerns over the patient's refusal to eat, weight loss, and social withdrawal. They support hospital admission but are unsure whether their child understands the severity of the situation.



🧠 Capacity Assessment Considerations

Under the **Mental Capacity Act (2005)**, capacity is decision-specific and must be assessed using the two-stage test:

1. Functional Test

Can the patient:

Understand the nature and purpose of hospital treatment?

Retain that information long enough to make a decision?

Use or weigh that information as part of the decision-making process?

Communicate their decision?

Observations:

The patient articulates a desire to remain at home and denies the need for treatment.

When asked about risks (e.g., cardiac arrest, organ failure), the patient minimizes concerns and expresses fear of weight gain.

Appears unable to weigh the risks of refusing treatment against the benefits of medical intervention.

2. Diagnostic Test

Is there an impairment or disturbance in the functioning of the mind or brain?

Yes: The patient has a diagnosed eating disorder (anorexia nervosa), which may impair judgment and insight.

📄 Conclusion

Based on the assessment, the patient **lacks capacity** to make an informed decision about hospital treatment due to impaired insight and inability to weigh risks appropriately. Immediate transport to hospital is justified under the **Mental Capacity Act**, with consideration for **Section 5** (acts in best interests) and potential escalation to **Mental Health Act** provisions if refusal persists.

🧠 Key Learning Points for Ambulance Staff

Eating disorders can severely impair capacity, even in articulate and seemingly rational patients.

Always assess capacity in relation to the specific decision at hand.

Document the assessment clearly, including patient responses and reasoning.

Liaise with mental health professionals and safeguarding teams as needed.

Case Study 4: Assessing Capacity in a Male Patient with Alcohol Dependence and Executive Dysfunction

Patient Overview

- Age: 45
- Gender: Male
- Living Situation: Supported accommodation (staff on-site)
- Presenting Issues: Chronic alcohol dependence, poor self-care, cognitive disorganization
- Current Concern: Not coping with daily living; concerns raised by support staff regarding safety, decision-making, and executive function.

Scene Description

Ambulance crew is called to a supported accommodation unit following concerns from staff that the patient is increasingly disoriented, missing meals, neglecting hygiene, and consuming large quantities of alcohol daily. He has had multiple falls in recent weeks and has refused GP appointments and detox referrals.

On arrival, the patient is found in a cluttered room, smelling strongly of alcohol, with visible tremors and slurred speech. He is alert but appears confused about the date and recent events. Staff report that he has been declining in function over the past month and is now unable to manage basic tasks like cooking or taking medication.



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🧠 Capacity Assessment Considerations

Under the Mental Capacity Act (2005), the two-stage test is applied:

1. Functional Test

Can the patient:

- Understand the need for medical assessment and possible detox?
- Retain that information long enough to make a decision?
- Use or weigh that information in the context of his health and safety?
- Communicate his decision?

Observations:

- The patient expresses a desire to “stay in my room and drink,” and denies any health concerns.
- When asked about recent falls and missed medication, he struggles to recall events and dismisses risks.
- He is unable to articulate the consequences of continued alcohol use or the benefits of medical intervention.
- His reasoning is circular and impulsive, suggesting impaired judgment.

2. Diagnostic Test

- Is there an impairment or disturbance in the functioning of the mind or brain?

Yes: Chronic alcohol dependence with suspected alcohol-related brain damage (ARBD), including signs of executive dysfunction (e.g., poor planning, disinhibition, impaired memory).



Conclusion

The patient lacks capacity to make informed decisions about his health and safety due to impaired executive function and cognitive decline. His inability to weigh risks and benefits, combined with memory deficits and disorganized thinking, indicate a need for urgent medical review.

Transport to hospital is justified under Section 5 of the Mental Capacity Act (acts in best interests), with consideration for further neuropsychiatric evaluation and safeguarding involvement.

Key Learning Points for Ambulance Staff

- Executive dysfunction may present subtly but has serious implications for capacity and safety.
- Alcohol-related brain damage can mimic dementia-like symptoms and impair decision-making.
- Supported accommodation staff are valuable sources of collateral history—listen to their concerns (best interest decision making-Principle 4 MCA).
- Document cognitive observations clearly and consider involving mental health crisis teams or adult safeguarding.



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- Executive dysfunction may present subtly but has serious implications for capacity and safety.
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What interventions would be appropriate for this case?

Great question. For a male patient with chronic alcohol dependence, living in supported accommodation and showing signs of executive dysfunction, a multi-pronged approach is essential. Here's a breakdown of appropriate interventions across medical, psychological, social, and safeguarding domains:

🔧 Appropriate Interventions

🧠 Cognitive & Capacity Support

- **Neuropsychiatric Assessment:** Referral for evaluation of executive function, memory, and possible alcohol-related brain damage (ARBD), including Wernicke-Korsakoff syndrome.
- **Formal Mental Capacity Assessment:** To determine decision-making ability regarding treatment, accommodation, and self-care. Who is the right person to assess capacity? SCAS? MH team? GP? Who knows the patient best? (Code of practice)

Substance Misuse Treatment

- Detoxification Program: Medically supervised alcohol detox, possibly in an inpatient setting if risk is high.
- Referral to Community Alcohol Services: For ongoing support, relapse prevention, and harm reduction strategies.
- Medication: Consideration of anti-craving agents (e.g., acamprosate, naltrexone) post-detox, if appropriate.

Physical Health Monitoring

- Hospital Admission: If medically unstable (e.g., falls, malnutrition, liver dysfunction), urgent admission may be required.
- Nutritional Support: Thiamine supplementation and dietary input to prevent Wernicke's encephalopathy.

Mental Health & Psychosocial Support

- Mental Health Team Involvement: Especially if there are signs of depression, cognitive decline, or psychosis.
- Occupational Therapy: To assess and support daily functioning, routines, and independence.
- Psychological Therapy: Once stabilized, consider CBT or motivational interviewing tailored to addiction and cognitive challenges.

Accommodation & Safeguarding

- Review of Supported Living Arrangement: Is the current setting meeting his needs? Consider higher-level support or residential care if functioning deteriorates. Could a welfare referral to the LA be appropriate- Section 9 assessment- The Care Act 2014.
- Adult Safeguarding Referral: If self-neglect or exploitation is suspected, involve local safeguarding teams.
- Multi-Agency Risk Management (MARM): To coordinate care between housing, health, social care, and addiction services.

Legal & Ethical Considerations

- Best Interests Decision-Making: If capacity is lacking, decisions about treatment and placement must follow the Mental Capacity Act framework.
- Consideration of Mental Health Act: If the patient is refusing treatment and poses a risk to self, detention under the MHA may be appropriate.

