Restraint and the Mental Capacity Act 2005 in operational policing

Mental Health & Policing – Briefing Sheet 4

This guidance was written to help police officers and partners working in health and social care understand how the Mental Capacity Act may be applied in high risk situations in which police officers are involved. It may be circulated freely to none police audiences and may help Borough Mental Health Liaison Officers explain the police position to the management and staff in local health trusts.
The Mental Capacity Act 2005

The Mental Capacity Act 2005 (MCA 2005) is designed to provide a legal basis for providing care and treatment for people aged 16 and over, who lack the mental capacity to give their consent. Whilst the Act is primarily aimed at health professionals and carers when making decisions about a person’s welfare, it will in some circumstances be applicable to police officers when dealing with members of the public.

The Act only applies to people who lack mental capacity or who are reasonably believed to lack mental capacity. It applies to public and private locations. When officers encounter a person, whom they reasonably believe to lack mental capacity, they should consider taking action to safeguard the person’s best interests, always having regard to how that purpose can be achieved in a way that places the least restrictions on the person’s rights and freedom of action.

The Act will be of primary importance to policing when officers deal with someone lacking mental capacity in an emergency situation, whose life may be at risk or who may suffer harm if action is not taken. Obvious situations will include people attempting and threatening suicide, victims of serious assaults and casualties following major incidents. In practice there may be many more examples. Police occasionally come across individuals with serious injuries that may result in serious harm or death, but who decline medical aid. If such a person has the mental capacity to make this decision there is no power to compel her/him to accept medical treatment.

If an officer reasonably believes that a person lacks mental capacity then the Act will apply and that person may be treated in their best interests. Officers must always weigh up the risks of forcing help on an unwilling person against the benefits it may offer. Unlike medical and ambulance personnel, police officers are not trained in the assessment of mental capacity. Where police are the only service on scene it may be necessary to make an assessment and act accordingly before other services arrive, where the seriousness or urgency of the situation dictates. When a doctor, member of the LAS or appropriate service arrives on scene, or is already present, police will defer to their expertise and provide support as appropriate. Any power to restrain a person as a result of the MCA 2005 does not interfere with any existing powers of arrest for criminal offences, or under S136 Mental Health Act 1983.

What is Mental Capacity?

Having mental capacity means having the ability to make a specific decision at the time that decision needs to be made. In other words being able to think through the steps necessary to make a decision

Why have a Mental Capacity Act?

The Act and its accompanying code of practice were mainly set out to regulate activities of professionals with responsibility for caring for and dealing with people with dementias, severe learning difficulties, brain injuries etc and for people to make arrangements in advance in anticipation that they would lose mental capacity in the future.

So how is this relevant to operational policing?

Significant parts of the Act and the Code of practice that accompany it do not have specific operational relevance to police officers but the MCA can be a very useful tactical tool for police officers to use when responding to high risk life threatening situations. Obvious examples include suicide attempts and threats and situations where someone with serious injuries refuses medical assistance.
What is a simple example of someone who is lacking capacity?

To cross a road safely, involves the ability to make decisions about the speed of approaching traffic and to decide when it is safe to cross without being struck by a vehicle. Would a heavily intoxicated person have the mental capacity to do this? Possibly not, since their thinking and brain function is temporarily impaired. They cannot think through clearly the decisions that need to be made at that particular time and may end up being seriously injured or killed as a result of lacking the mental capacity to judge traffic conditions.

How does this apply to a suicidal individual whom I come across as a police officer?

Form 434 provides a decision making tool for officers to follow to provide guidance when responding to these kinds of situations where Mental Capacity is an issue. In these situations officers should always call the LAS to the scene and request to assess mental capacity. However in many cases there will not be time to await their arrival and the following guidance will apply to officers faced with the need to make an urgent decision.

The ideal response to a suicidal individual in a public place will be to consider the use of Section 136 Mental Health Act 1983, which most Police Officers should be very aware of and understand sufficiently enough to use operationally. There are sound reasons for this. If Section 136 is used there is a power to keep the person detained at a place of safety until an assessment has taken place, regardless of how the person’s behaviour changes after arrival at the place of safety. In contrast, a person’s mental capacity can fluctuate and with it the power to keep holding them. This means that where someone attempting/threatening suicide is restrained (relying upon MCA) and taken to A & E for assessment/treatment, they could only be kept against their will at A & E using restraint as long as their mental capacity is impaired. If, having arrived at A & E they later seem to be perfectly lucid and rational and appear to have capacity, there would no longer be power to restrain them. S136 is arguably a more clear cut intervention and where it can lawfully be used, it should be used in preference to MCA.

However in private premises Section 136 should not be used and Mental Capacity legislation could offer a tactical solution. The first question to consider when faced with a suicidal individual in private premises is - "Do you believe the person has an impairment of the mind or brain, or is there some sort of disturbance affecting the way their mind or brain works? (It doesn't matter whether the impairment or disturbance is temporary or permanent)"

Evidence of such an impairment might be obvious for example from a number of observations that show the person is suffering from severe distress, irrational thought processes, acute trauma, intoxication, concussion, confusion, dementia. The majority of people who police come across in suicidal/serious self harm type situations will normally fall into one of these categories and generally will be acutely traumatised and in some kind of distress.

Therefore if the answer to this question is YES then the second question to consider will be “Does the impairment or disturbance mean that the person is unable to make a specific decision when they need to make it?” – A person is suicidal for a reason – normally due to some traumatic event and it is arguable in the fast moving immediate situations that Police deal with that their acute trauma is preventing them from thinking through and making a rationally thought out choice. Such a rationally thought out choice might include seeking medical assistance or support of family/friends/counsellors etc to deal with their acute trauma. The person’s inability to consider these alternative choices can strongly indicate that the person is lacking the mental capacity to end their own life at that particular time. Form 434 steps officers through a slightly more detailed way of making this decision, but this is essentially what it will amount to.
If having considered these 2 questions I believe that the person lacks mental capacity, could I be criticised if someone more qualified than me or a court decide the person did not lack mental capacity?

This is a common question, as is “how can I be confident my decision that someone lacks mental capacity can stand up to scrutiny or to be challenged?” The MCA requires that officers take reasonable steps to determine someone’s mental capacity and that they have a reasonable belief that the person lacks capacity. Clearly, the majority of suicidal type situations that police encounter are fast moving and require rapid preventative action with little time for leisurely reflection. Providing that officers show they have considered the person’s state of mind and as a result of talking to the person they have formed the belief they lack capacity as a result (for example) of their acutely distressed, traumatised, uncommunicative state, and they have acted in the genuine belief they need to save the person’s life then it is highly unlikely that any criticism would succeed. It is equally important to consider the alternative criticism of not acting and walking away and the person then successfully does commit suicide!

Must officers be absolutely sure that the person lacks capacity?

The short answer to this is definitely no. All that is required is that officers believe on the balance of probability that the person lacks capacity. This means that in the particular circumstances the officer thinks that it is more likely than not that the person is lacking mental capacity. Making a decision that someone lacks capacity is in practice similar to any other decision for which police are accountable such as decisions to stop and search and decisions to arrest.

Having formed a reasonable belief that the person I am confronted with is lacking mental capacity, what should I do next?

The next and final step in the decision making process is to ask “before I decide to take action (for example with this suicidal person) will the action I propose to take be in that person’s best interests?” The code of practice to the MCA says that in emergencies it will almost always be in someone’s best interests to give urgent treatment without delay. With the majority of life threatening situations encountered by Police it will be relatively easy for officers to show they reasonably believed that it was in the person’s best interests to act to save their life.

So where a Police officer believes a person lacks capacity and is for example suicidal, what action can that officer actually take?

Someone who is suicidal and lacks mental capacity to make decisions about their own healthcare needs is in a similar situation to someone with very serious injuries (following an assault, road traffic collision, major incident) who through the trauma of that situation or even through intoxication, lacks the capacity to appreciate the risks to their health if they do not get urgent treatment. In these situations officers can and should consider ensuring the person concerned receives medical treatment. This can include using restraint to force a person to attend A & E against their will.

If I decide to force someone to go to A & E then what restraint can I use?

Officers should reasonably believe that it is necessary to restrain the person to prevent the person suffering harm and that the restraint/taking the person to A & E is a proportionate response to the likelihood of the person suffering harm and the seriousness of harm. Clearly in both suicidal/serious self harm and serious injury situations it will be relatively uncomplicated for officers to be able to demonstrate the need to use restraint where the person resists or refuses. However where a person with serious injuries physically resists any attempt to compel attendance at A & E, it will be safer to keep them under observation until the arrival of the LAS and act under their advice.
What about someone who is terminally ill and decides to end their own life?

Many cases of suicidal behaviour that officers encounter involve a seriously traumatised; acutely distressed and/or intoxicated person and applying the Act as outlined will be relatively straightforward. Less common are situations where someone is perhaps perfectly calm and rational and has decided over a period of time to end their life. A police officer called to this kind of situation may feel less confident in making a decision about capacity and using restraint. Officers are unlikely to be criticised for intervening to save life where the urgency of the situation dictates but where doubt exists and time allows then the option of requesting the person’s own doctor, the LAS or even the FME to attend the location and assess mental capacity may often be safer responses.

What about people who are self-harming in police custody?

The use of the MCA is equally valid for people held in MPS custody. Where someone is already detained under the authority of PACE then officers would in any event respond by requesting an FME to assess the person with a view to seeking a mental health assessment whilst in custody and detention would be under authority of PACE rather than relying upon MCA. The MCA is particularly helpful however for custody officers in cases where a pre-release risk assessment reveals a high risk that the person will attempt to take their own life as soon as they are released from police custody. Where this happens it would be legitimate for the custody officer to either restrain the person for a short time awaiting an FME or LAS to attend and assess mental capacity or where delay occurs to take the person to A & E in a police vehicle. Restraint in this context would simply be continuing to hold the person in custody for a short time and/or transferring them to A & E.

Why should someone be taken to A & E rather than a place of safety?

Someone restrained by police relying upon MCA is not detained under Section 136 and would not ordinarily be taken therefore to a place of safety. It is important to recognise that where a police officer takes action relying upon MCA in suicidal/serious self harm or serious injury situations such action is taken to ensure the person receives the medical attention they require, which may or may not involve a mental health assessment.

What if staff at A & E refuse to deal with the person?

Once police have arrived at A & E and have attempted to explain the circumstances to medical staff then further decisions about continuing to restrain the person and any treatment they should receive are entirely a matter for A & E staff. If having explained the circumstances, A & E staff decline to deal with the person concerned this should be recorded in Form 434 and the person will at that point be free to go. A & E staff are accountable for the response they provide and the National Guidelines for clinical excellence outline what A & E staff should do when a person with serious self harm issues presents at their department. Form 434 reproduces these guidelines in a tear out sheet that officers should hand to A & E staff when they take a person they have restrained relying upon MCA. The MCA code of practice is clear that the most qualified professional should make decisions about capacity and police must defer to the expertise of the A & E staff.

What is the correct police response to pre-planned requests from partners in health and social care to restrain someone on their behalf?

A number of instances have arisen since the inception of the Act where Police Officers have been requested by practitioners in health and social care to use the Act in situations which are not an immediate emergency. These have involved instances where someone lacking mental capacity needs to undergo a pre-planned surgical or medical procedure or requires treatment which is not immediately life saving but refuses to do so. This is an
inappropriate use of Police resources and where restraint is used on an already vulnerable patient, could have far reaching consequences for the reputation of the MPS. Requests to restrain in these circumstances must be declined. Health and social care staff can rely upon the Act to restrain in these cases and where the person lacks capacity and the proposed surgical treatment is in their best interests should be advised to do so without Police involvement.

**What are the deprivation of liberty safeguards?**

Known as DOLS, the Deprivation Of Liberty Safeguards permit someone who lacks mental capacity in certain circumstances and who meets a number of conditions to be deprived of their liberty in a care home or hospital. Typical examples might include an elderly person with dementia or a younger person with severe learning difficulties who is mentally incapable of looking after themselves. Where all the relevant criteria are met then an authorisation can be given by the supervisory body (an NHS trust or a local authority) effectively authorising that the person be deprived of their liberty in a care home.

In some cases a person may be living in their own environment and require moving into the care home where the DOLS authority deprives them of their liberty. The body who have applied for the authorisation (normally the care home management) are responsible for taking this action. Where necessary they may rely upon Sections 5 and 6 of the MCA to do so. A number of cases have arisen in London where local officers have been requested to carry out this function or assist health and social care staff to do so. Such requests should be refused. People requiring DOLS authorities are highly vulnerable and the DOLS code of practice describes the majority as either suffering from dementia, serious learning disability or brain injuries. It follows that risks of death or serious injury during restraint are therefore more likely.

Since these events will be pre-planned it is possible for health trusts to assemble sufficient staff and transport and consider the use of private ambulances and trained security companies.

Enquiries about this guidance should be addressed to Inspector Mike Partridge TPHQ - Tel: 020 7161 1019

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