

Mental Capacity Act 2005

Core Training Set



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Foreword

I am pleased to introduce these excellent new training materials on the Mental Capacity Act 2005 (MCA). They have been developed by the University of Central Lancashire (UCLAN) and the Social Care Workforce Research Unit at King's College, London, and provide in-depth information and guidance on what the new MCA will mean to people like you working in health and social care. The MCA will apply to everyone who works in health and social care and is involved in the care, treatment or support of people who lack capacity to make their own decisions or to consent to the treatment or care that is proposed.

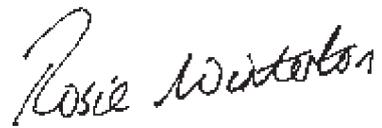
The MCA puts the individual who lacks capacity at the heart of decision making and places a strong emphasis on supporting and enabling the individual to make their own decisions or involving them as far as possible in the decision-making process.

You will all have a vital role to play in the implementation of the MCA. Your role will begin in April when some parts of the MCA come into force – including the new Independent Mental Capacity Advocate (IMCA) service and the new criminal offences of ill-treatment or wilful neglect of a person who lacks capacity.

The MCA Code of Practice, recently passed by Parliament, provides the foundation of the training materials. It will be useful to become familiar with the Code, which explains how the MCA will work on a day-to-day basis. As you will know, because you work with people who lack capacity in a professional or paid capacity, you have a duty of regard to the Code. The training materials complement the Code and are a wide-ranging and comprehensive package, which, together with the Code, will ensure that you have the relevant knowledge and skills to meet the demands of the new MCA.

The new MCA will play an important part in safeguarding and protecting those people in society who lack capacity to do so for themselves. Working in health and social care, you will be playing a vital part supporting and caring for some of the most vulnerable people in society and I am confident that you will rise to the challenge posed by the new MCA.

The training is interactive and I know that you will be engaged and stimulated by the material. I hope that the training will leave you with a full understanding of your new role in relation to the MCA, and, most importantly, of your responsibilities to those in your care who lack capacity.

A handwritten signature in black ink that reads "Rosie Winterton". The signature is written in a cursive, flowing style.

Rosie Winterton
Minister of State (Health Services)

1 Introduction

1.1 Who is this training for?

This training is for staff working with the Mental Capacity Act 2005 (MCA) in England and Wales. It is designed to be used as the basis for training sessions for staff who are working with people whose capacity to make particular decisions may be uncertain or questionable, and for training those working with people who wish to plan ahead or make their decisions in advance. It can be used in three main ways:

- as the basis for staff training sessions
- for individual learning and continuing professional development
- as a resource that staff can consult in the course of their day-to-day practice.

This set of core materials is broadly based to cover the knowledge needed by people working in a range of health and social care settings. You may also be interested in the more detailed training sets aimed at staff working in specific settings. These are:

- acute hospitals
- mental health services
- residential accommodation
- primary and community care.

The Core Training Set comprises four learning hours for continuing professional development purposes, and there is a certificate included at the back of this pack that you can complete and forward to your professional training organisation or employer when you have worked through these materials.

1.2 Introducing the Mental Capacity Act

The MCA is being implemented in two distinct phases in 2007.

In April 2007:

- the new Independent Mental Capacity Advocate (IMCA) service became operational in England only
- the new criminal offences of ill-treatment or wilful neglect came into force in England and Wales

- Sections 1–4 of the Act (the principles, assessing capacity and determining best interests), which are essential to how IMCAs do their work, also came into force, but only in situations where an IMCA is involved and/or for the purposes of the criminal offences. Sections 1–4 of the Act will not apply in any other situations until October 2007
- the Code of Practice for the Act was issued and should be followed by those who must have regard to it in situations where an IMCA is involved or in relation to the new criminal offences.

In October 2007:

- all other parts of the Act come into force, including the IMCA service in Wales
- the Code of Practice will have statutory force for all of the Act, not solely in relation to IMCA involvement and/or the criminal offences.

The MCA is different from the Mental Health Act 1983. Some people may be affected by both Acts. See the training set on mental health for further details.

1.3 Using this training

A range of training tools is provided here, including case studies and a model PowerPoint presentation. This is to ensure that the materials can be used by front-line staff in different settings ranging from service users' own homes to acute hospitals. All sets of materials are available in hard copy, CD Rom and online at: www.dh.gov.uk/mentalcapacityact

Those using the training are encouraged to refer to the Code of Practice on the MCA for more detailed guidance, and references to the Code of Practice are included throughout.

If you are using the pdf version of this training set you can move around it and to other documents mentioned in the text, such as the Code of Practice, by clicking on the underlined chapter headings or references. Where the PDF features recordings of the service users' and carers' quotations you can click on these to hear their words spoken.

In some places, this Core Training Set employs language and phrases that are used in the legislation. References to the relevant sections are included in the text. You can find a glossary of relevant terms towards the back of this pack.

The case studies and examples are included here for discussion and to show how the MCA and the Code of Practice will work in practice. They are not provided as examples of what **must** be done, because each assessment of capacity and best interests-led decision will be determined by individual circumstances.

This training has been developed in collaboration with service users, carers and practitioners who have provided some of the case examples we have used. The quotations included here express their opinions of the MCA. These are their views and are not a guide as to how the Act should be applied in specific situations. We are grateful for their comments.

1.4 Service users and carers

Service users and carers who contributed to the development of this training were very positive in their responses to the MCA and to this training:

"Well it's about empowerment and protection of vulnerable people ... I think they are very good principles, I think they are very good intentions."

Service users were very interested in the role of the IMCAs (see Part 10 of these materials). Many felt that this type of advocacy should be available to a broader group of people. They noted that family and friends aren't always best placed to act in their best interests or to challenge the recommendations or decisions made by professionals. When asked what they considered most useful in the MCA, service users said:

"The most helpful are the IMCAs because they are trained, because they are knowledgeable and because they are independent."

"Definitely the advocates. I think the advocates would be number one for me."

Service users and carers were also very positive about advance decisions.

Isabel is in her eighties and has been a service user and a carer.

She commented:

"Advance decisions, well I'm seriously thinking about a living will myself ... I think my family want me to make known my wishes, and perhaps the Act will advance decision making in that way so that people can take more responsibility. I do think as a society we should take more responsibility for expressing our wishes, make known our wishes. We should face death more realistically than we do."

Service users and carers consulted over this training believe that the MCA will only be as good as the training and information available about it for all involved, including staff, carers, family, friends and people who may lack capacity now or at some stage in the future. They think that the attitudes and practices of many staff involved will have to change and that better communication between service providers and service users will be essential.

Eileen, an older person who has been receiving hospital treatment, said about staff training:

"I think they should have some training in understanding that lay people have different ideas; that different things are important to lay people and professionals and that professionals should respect or, at the very least, listen to and try to understand what it is to have lived experience of an issue."

Users and carers asked how the MCA is being monitored. The Office of the Public Guardian is playing a role in monitoring what happens under the Act. The Commission for Social Care Inspection (England), the Care and Social Services Inspectorate for Wales, the Healthcare Commission (England) and the Healthcare Inspectorate for Wales will look at practice in care homes, home care and hospitals, for example, under the revised National Minimum Standards. Overall, service users said it would be important to publicise and promote the MCA.

1.5 Which staff will be affected by the Mental Capacity Act?

The MCA applies to all people making decisions for or acting in connection with those who may lack capacity to make particular decisions. The staff who are legally required to have regard to the Code of Practice when acting in relation to a person who lacks, or who may lack, capacity are as follows:

- people working in a professional capacity, e.g. doctors, nurses, social workers, dentists, psychologists and psychotherapists
- people who are being paid to provide care or support, e.g. care assistants, home care workers, support workers, staff working in supported housing, prison officers and paramedics
- anyone who is a deputy appointed by the Court of Protection
- anyone acting as an IMCA
- anyone carrying out research involving people who cannot make a decision about taking part.

1.6 The Code of Practice

The Code has an important role in the operation of the MCA and needs to be consulted by everyone involved in the care of people who may lack capacity to make decisions.

The Code of Practice provides legal guidance on the operation of the MCA and best practice and should be followed in order to justify your actions and interventions.

The Minister of State for Health Services (March 2006) said that:

"... the Code of Practice will ensure that best practice is followed and strict safeguards are in place to protect these most vulnerable people ..."

1.7 Why do we need the Mental Capacity Act?

The MCA has been developed to bring together existing legal requirements and provide consistency in decision making about the care and treatment of people who lack capacity to make a decision. Much of the Act builds on existing common law (that is, law that is established in judgments made by the courts), but it also brings in important changes, including new criminal offences, IMCAs, a new Court of Protection and the Office of the Public Guardian.

The MCA is designed to protect the rights of individuals and to empower vulnerable adults. In the past, some people with dementia, learning disabilities and severe mental illness have often not been listened to, and their rights to make decisions may not have been recognised.

The MCA covers decisions that range from day-to-day decisions such as what to eat and wear, through to serious decisions about where to live, having an operation or what to do about a person's finances and property.

Isabel said:

"I think it's probably the most vulnerable group in society that we are looking at in terms of people who lack mental capacity. So we are looking at people that our society as a whole must be judged by in terms of what care we give. How do we measure their quality of life compared with the rest of the citizens in our society?"

At this point, you have:

- **heard users' and carers' views and expectations of the MCA**
- **identified which staff will be affected**
- **been alerted to the importance of the Code of Practice.**

2 Definitions and principles

2.1 Who will be affected by the Mental Capacity Act?

Some people will be affected because their capacity to make particular decisions is an issue. However, anyone could choose to use parts of the Mental Capacity Act 2005 (MCA) for future planning.

In general, the MCA applies to people aged 16 years and over, but there are some exceptions (see Part 13 of these materials).

It is difficult to be precise about the exact number of people who lack capacity to make decisions, and often people are able to make some decisions but not others. Government estimates for England and Wales suggest that between 1 and 2 million adults may have issues concerning their mental capacity, and these include approximately:

- 840,000 people with dementia (though not everyone with dementia lacks capacity)
- 145,000 people with a severe learning disability
- 1.2 million people with a mild to moderate learning disability (many do not lack capacity)
- 120,000 people with a severe brain injury.

2.2 What is mental capacity?

Mental capacity within the context of the MCA means the ability to make a decision. A person's capacity to make a decision can be affected by a range of factors such as a stroke, dementia, a learning disability or a mental illness. People with a mental illness do not necessarily lack capacity. However, people with a severe mental illness may experience a temporary loss of capacity to make decisions about their care and treatment.

A person's capacity may vary over time or according to the type of decision to be made. Physical conditions, such as an intimidating or unfamiliar environment, can also affect capacity, as can trauma, loss and health problems. A temporary lack of capacity will also include those who are unconscious or barely conscious whether due to an accident, being under anaesthetic or as a result of other conditions or circumstances such as being under the influence of alcohol or drugs.

2.3 Five core principles of the Mental Capacity Act (Mental Capacity Act, Section 1; Code of Practice, Chapter 2)

The following core principles must be followed in any assessment of or decision about a person's capacity. Staff who provide health or social care will need to keep a record of all assessments and decisions they have made. This should be included in the person's file or case notes.

BOX 1

The five core principles

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 (doable) 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.
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 their 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.

Jenny, a mental health service user, said:

"I think it is particularly good actually that it is in there that people can make decisions that are eccentric or that you disagree with."

Isabel is in her eighties and has been a service user and a carer. She commented:

"I think that our risk-averse society has got to be really careful not to be too risk averse, which is where I think we've moved to, which relates to people's freedoms."

2.4 What is lack of capacity? **(Mental Capacity Act, Section 2; Code of Practice, Chapter 4)**

A person lacks capacity if they are unable to make a particular decision because of an impairment or disturbance of the mind or brain, whether temporary or permanent, at the time the decision needs to be made.

Under the MCA, the following factors have to be considered when assessing if someone has capacity to make a decision:

- whether they are able to understand the information
- whether they are able to retain the information related to the decision to be made
- whether they are able to use or weigh that information as part of the process of making the decision
- whether they are able to communicate that decision – by any means, including blinking an eye or squeezing a hand.

Capacity is both time and decision specific. As a rule, most people will be able to make most decisions most of the time. A lack of capacity can change over time; a person may have the capacity to make some decisions but not others.

BOX 2

Examples

1. Janine has severe learning disabilities and lives in a care home. She is able to choose what to eat and drink and makes these decisions for herself. She does not always have the capacity to decide on appropriate clothing for the weather, and care assistants make these decisions for her when necessary.
2. Bob has recently received a diagnosis of Alzheimer's disease. He wants to put his affairs in order, and does this by making a will with the help of his solicitor. The consultant has advised him to give up his hobby of woodwork, but Bob continues to do this, taking more care with the electrics and his knives because he still has the capacity to make these decisions.
3. Zelma enters into a new tenancy agreement with the advice of her support worker, and signs the paperwork with a cross, as she is no longer able to write her name after her stroke. Like Bob, she has the capacity to make this decision, and staff should not assume otherwise.

Under the MCA, you cannot decide that someone lacks capacity just by a person's age, appearance, condition or an aspect of their behaviour that might lead to unjustified assumptions about capacity. So, in the final example in Box 2, although the housing officer was not sure whether Zelma was able to understand what she was signing as her speech sounded slurred and incoherent, Zelma's support worker was able to assure him that Zelma understood sufficiently and that his assumptions were not justified.

Most people will be able to make most decisions most of the time.

At this point, you have:

- learnt how mental capacity is defined
- been introduced to the five core principles of the MCA
- discovered that capacity is time and decision specific.

3 Assessing capacity

3.1 What triggers an assessment?

As stated in the principles of the Mental Capacity Act (MCA), you should always start from an assumption of capacity. Doubts as to a person's capacity to make a particular decision can occur because of:

- the way a person behaves
- their circumstances
- concerns raised by someone else.

BOX 3

Example

Rhys, who has moderate learning disabilities and autism, makes most decisions about his finances, but he has a new girlfriend and is now spending considerable amounts of money on new clothes. He has stopped contributing money to the household budget of the group home where he lives. His care manager decides to call a meeting with others involved in his support to discuss her concerns.

In this example, the trigger is Rhys' behaviour.

Other important triggers could be the death or move of a person who has been providing care, or a referral to an adult protection co-ordinator. Any doubts must be considered in relation to the specific decision to be made.

Also, remember that an unwise decision does not necessarily indicate lack of capacity.

3.2 What do you need to ask when assessing capacity?

There are two questions to be asked if you are assessing a person's capacity.

The two-stage test of capacity (Code of Practice, 4.11–4.15)

- Is there an impairment of, or disturbance in, the functioning of the person's mind or brain?

If so:

- Is the impairment or disturbance sufficient to cause the person to be unable to make that particular decision at the relevant time?

This two-stage test must be used, and you must be able to show it has been used. Remember that an unwise decision made by the person does not of itself indicate a lack of capacity. Most people will be able to make most decisions, even when they have a label or diagnosis that may seem to imply that they cannot. This is a general principle that cannot be over-emphasised.

The assessment process has to be clear and accountable. It will require input from staff in the range of organisations involved in providing support, and should include family and carers. Where there is no family or carer or other person authorised to make decisions for that person, an independent mental capacity advocate (IMCA) may be assigned if there is an important decision about certain medical treatment or a change of accommodation to be made (see Part 10 of these materials). Other advocates may also be able to offer support, representation or advice, and staff need to be familiar with the local services and know how to contact them.

All professional staff involved in an assessment should keep adequate records that explain the grounds on which a person is found to have, or lack, capacity.

3.3 Assessing capacity in relation to different types of decisions (Code of Practice, 4.49–4.54)

The starting point is that a person has capacity to make the decision in question. A finding that a person lacks capacity to make a decision should not be made lightly. A formal, clear and recorded process should be followed when an important decision such as a move or medical decision is to be made.

Day-to-day assessments of capacity may be relatively informal but still should be written down by staff. This may require a shift in practice, as many of these informal decisions have been made in the past without being recognised as decisions about capacity. For example, a home care worker may have undertaken food shopping for an older person with dementia without consulting them about what they would like to eat. If there are no ways of seeking their views on this and they are not able to contribute to decisions about what food should be bought, this should be discussed with the home care worker's supervisor and the decisions recorded.

Martin, who has learning disabilities, commented:

"I know of a place where staff working in a group home for people with learning disabilities have always looked after the residents' money for them."

The MCA means that staff will not be able to make 'blanket decisions' like this about groups of service users. They will have to assess the capacity of individual residents to make particular decisions for themselves and record these decisions.

As noted in 2.4 above, any assessment of a person's capacity **must** consider the following factors:

- whether they are able to understand the information
- whether they are able to retain the information related to the decision to be made
- whether they are able to use or weigh that information as part of the process of making the decision.

The person has to be able to do all three to make a decision and they have to be able to communicate that decision. This could include alternative forms of communication such as sign language or blinking an eye or squeezing a hand when verbal communication is not possible.

The staff involved should record their assessment of these factors. Responsibility for this will depend upon the situation and the individual's circumstances.

Assessing capacity will always depend upon the individual being assessed. Medical assessment, for example, while relevant, would not necessarily be the only, or even the main, assessment method. Specialist or expert opinion may be helpful sometimes, but knowledge of the person concerned, for example that of family and friends, is very important. And, as noted above, most people are able to make most decisions.

BOX 4**Example**

Claude lives in a care home but his dementia is causing him great distress. Fellow residents are also upset by his actions, even though they know he is ill. Does he have capacity to consent to move to a new home where staff may be able to offer him more support? This is a decision where the views of several professionals, including his GP, the consultant psychogeriatrician, the community nurse who sees him regularly and the home manager, will be required. The care manager is responsible for co-ordinating the assessment of Claude's capacity to make this decision. The care manager will also find it helpful to talk to Denise, Claude's great-niece, who has known him for many years and still visits him occasionally.

3.4 Assessing capacity in practice

Anyone who is being assessed for capacity to make a decision should be assessed at their best level of functioning for the decision to be taken. This will be best achieved by approaches similar to those listed below in Part 3.5, What sort of help might a person need to make a decision?

The following factors demonstrate the range of areas that will need to be considered. As always, the range of areas to be considered will be specific to the individual and their circumstances, and the two-stage test of capacity must be applied. Do you remember what this is? Please see Part 3.2 of these materials.

Factors to be considered in an assessment:

- General intellectual ability
- Memory
- Attention and concentration
- Reasoning
- Information processing – how a person interprets what they are told
- Verbal comprehension and all forms of communication
- Cultural influences
- Social context
- Ability to communicate

Not all of these factors need to be considered in every assessment of capacity although, for some formal assessments, a number of these factors will be relevant. A reasonable belief in a person's lack of capacity to make a particular decision should be supported by judgements about some of these factors.

Each assessment of capacity will vary according to the type of decision and the individual circumstances. The more complex or serious the decision, the greater the level of capacity required. The questions in Box 5 must be addressed.

BOX 5

Questions to consider
(Code of Practice, 4.44–4.49)

- Does the person have a general understanding of what decision they need to make and why they need to make it?
- Do they understand the consequences of making, or not making, the decision, or of deciding one way or another?
- Are they able to understand the information relevant to the decision?
- Can they weigh up the relative importance of the information?
- Can they use and retain the information as part of the decision-making process?
- Can they communicate their decision?

How would you put these questions to Claude if you were assessing his capacity to decide on a move to a new home, as in the example in Box 4?

Once a person has been assessed as lacking capacity to make a decision, you may need to make a best interests decision on their behalf (see Part 4 of these materials). In Claude's case, the best interests decision following on from an assessment which determined that he did not have the capacity to make this decision himself would address the question of whether he should move to a new home.

Who will assess capacity?

Anyone caring for or supporting a person who may lack capacity could be involved in an assessment. Remember, each decision needs to be considered alongside the person's capacity to make it. For example, care home staff

may regularly make day-to-day assessments of capacity when asking residents whether they want to do one thing or another. One person may be able to choose whether to use an incontinence pad, while others lack the capacity to make this decision.

The more significant the decision to be made, the more likely that a number of different professional staff will be involved. In Claude's case, for example (see Box 4), doctors, nursing staff, social care staff and his relative will all contribute to the assessment of his capacity to make the decision about moving.

3.5 What sort of help might a person need to make a decision?

You must always bear in mind the five core principles and ensure that no one is treated as unable to make a decision unless all practical steps to help them have been exhausted and shown not to work.

Steps to be taken (Code of Practice, 3.10–3.16)

- Provide all relevant information but do not burden the person with more detail than required. Include information on the consequences of making, or not making, the decision. Provide similar information on any alternative options.
- Consult with family and other people who know the person well on the best way to communicate, e.g. by using pictures or signing. Check if there is someone who is good at communicating with the person involved.
- Be aware of any cultural, ethnic or religious factors which may have a bearing on the individual. Consider whether an advocate (in Part 10 of these materials you will see that an IMCA is only likely to be involved in a limited number of cases, so we mean a general advocacy service here) or someone else could assist, e.g. a member of a religious or community group to which the person belongs.
- Make the person feel at ease by selecting an environment that suits them. Make sure it is quiet and unlikely to be interrupted. Arrange to visit relevant locations; for example, if the decision is about a hospital or short-break stay, visit the place with them. See if a relative or friend can be with them to support them.
- Try to choose the best time for the person. Try to ensure that the effects of any medication or treatment are considered. For example, if any medication makes a person drowsy, see them before they take the medication, or after, the effect has worn off.

- Take it easy. Make one decision at a time, don't rush and be prepared to try more than once.

Marion, whose daughter Anna has multiple disabilities and no speech, has made a communication passport that can be used to help staff communicate with Anna in relation to the decisions she can make:

"It explains what Anna's emotional responses mean, as far as we are able to do so. Each day, wherever she is, staff record what she has done and what her responses to those activities are. This gives us a long-term view on what Anna is trying to tell us about her services and assists us in voicing the decisions that she is making through her non-verbal communication ... when Anna was admitted to hospital for a planned operation, her communication passport was put with her nursing notes and all nursing staff were encouraged to read it."

You may like to use case study 1 on communication and consultation now.

3.6 Legal tests under common law and other legislation

Although the MCA brings together much of existing common law and establishes the way in which capacity must be assessed, some decisions will continue to be dealt with under common law (that is, law established through decisions made by courts in individual cases). Where a legal decision needs to be made, staff must be fully aware of those decisions that are covered by the MCA and those which are covered by common law or other legislation.

There are several tests of capacity that have been produced following judgments in court cases. These are known as common law tests. They cover capacity to:

- make a will
- make a gift (although attorneys can also make gifts – see Part 6.4 of these materials)
- enter into litigation (take part in legal cases)
- enter into a contract
- enter into marriage.

Other professionals will need to be involved in administering these tests of capacity under common law. For example, it is advisable to seek legal advice from a legal practitioner when people who may lack capacity are making a will, and registrars will continue to decide if somebody has the necessary capacity to understand the marriage vows.

Other acts, for example the Juries Act 1974, have been amended to include the MCA's definition of lacking capacity. A lack of capacity to serve on a jury disqualifies somebody from jury service.

For more information on common law tests and their use, see the British Medical Association and Law Society book, *Assessment of Mental Capacity – Guidance for Doctors and Lawyers*, Second Edition. Please check that you use the latest edition – as the law develops and decisions are made about individual cases, some of the guidance will change.

3.7 Excluded decisions

Other decisions excluded from the MCA include:

- consent to sexual relations
- consent to divorce or dissolution of a civil partnership
- consent to a child being placed for adoption or to making an adoption order
- voting.

Other people can never make these decisions on behalf of another person, regardless of the person's capacity to make these decisions themselves.

Sexual relationships

Sexual relationships involving a person who may lack capacity to consent can pose complex dilemmas for staff and families. The MCA does not give anyone the power to consent to sexual relationships on behalf of a person who lacks capacity.

BOX 6

Example

Lynette has dementia and is often very confused. She lives in a care home where a number of her day-to-day decisions are made for her. She has started a relationship with Harry, another resident, and staff think that they may be sleeping together. Lynette's son, Mark, is unhappy about this development and tells staff that his mother is being taken advantage of, as she does not have the capacity to consent to this relationship. Staff are unwilling to intervene as Lynette and Harry seem very fond of each other.

Lynette has the capacity to consent to sex if she can understand information about the nature and likely consequences of having sex.

Nobody can make the decision to consent on Lynette's behalf to have sex. She must have the capacity to decide for herself and be able to communicate that decision. Staff will need to establish this by talking with Lynette and by observing her behaviour to ensure she is not being abused. If they conclude that Lynette does not have the capacity to consent or if she has capacity but seems unhappy about her sexual relationship with Harry, staff should seek advice from their manager, who may wish to contact the local adult protection co-ordinator.

The Sexual Offences Act 2003 may also be relevant in such cases. Copies of the Act and associated guidance are available on the Home Office website at: www.homeoffice.gov.uk. See also the Home Office leaflet *Adults: Safer from Sexual Crime*.

3.8 What kind of records will staff need to keep? (Code of Practice, 4.60–4.62)

Day-to-day records

Where a person is judged to lack capacity to consent to day-to-day care, elaborate record keeping is not required. However, if a practitioner's decision is challenged, they must be able to describe why they had a reasonable belief of lack of capacity. The decision about the lack of capacity should always be recorded in the person's case notes or file. Although this does not need to be done on a daily basis, the record should note the decision and note that it will be reviewed regularly. Recording decisions in this way will help staff to demonstrate why they had a reasonable belief in the person's lack of capacity.

For example, the care record for Raymond, who is severely disabled by a stroke, might state:

"Raymond was unable to tell me whether he wanted a shave today, so a decision was made that a shave would be in his best interests. I will assess his capacity to decide about this again next week, or earlier if he shows signs of improvement."

Some employers will have policies about what they require in respect of such documentation.

Professional records

Where professionals such as occupational therapists, nurses, social workers, psychologists or doctors are involved, it is good practice for a proper assessment of capacity to be made and the findings recorded in the relevant records. These records will be useful for other people involved in the person's care, or if your practice is challenged. Daily notes on an individual's care should be part of this process. Local agency protocols and procedures should cover this.

Reports for the Court of Protection/Office of the Public Guardian

Formal reports or access to records may be required in certain circumstances by the Court of Protection or Office of the Public Guardian. It is therefore important that records are maintained and kept up to date.

You may like to use case study 2 on assessing capacity now.

At this point, you have:

- **been introduced to the two-stage test of capacity**
- **identified what needs to be considered when assessing capacity**
- **discovered when a legal practitioner should be consulted about a person's capacity to make certain legal decisions**
- **noted the importance of recording decisions about assessing capacity.**

4 Making decisions and acting in a person's best interests

4.1 Best interests decisions and acts (Code of Practice, 5.1–5.69)

The Mental Capacity Act (MCA) requires any decision or act made on behalf of a person who lacks capacity to be made in that person's best interests. Decisions may be made under the MCA by people appointed to do so, such as attorneys, deputies and the Court of Protection (see Parts 6 and 8 of these materials). However, decisions will often be made by staff involved in the care and treatment of the person concerned. Staff can also undertake most acts in connection with care or treatment which are made on behalf of a person who lacks capacity to consent if those acts are in a person's best interests.

The MCA does not define best interests but identifies a range of factors that must be considered when determining the best interests of individuals who have been assessed as lacking capacity to make a particular decision or consent to acts of care or treatment. There are a number of steps involved in deciding what a person's best interests are. The MCA makes it clear that, when determining what is in someone's best interests, you must not base the decision on the person's age or appearance or make unjustified assumptions based on their condition.

The factors that must be taken into account when determining what is in someone's best interests are set out in the best interests checklist (MCA, Section 4; Code of Practice, 5.13):

- Considering all relevant circumstances – these are circumstances of which the decision maker is aware and those which it is reasonable to regard as relevant.
- Regaining capacity – can the decision be put off until the person regains capacity?
- Permitting and encouraging participation – this may involve finding the appropriate means of communication or using other people to help the person participate in the decision-making process.
- Special considerations for life-sustaining treatment – the person making the best interests decision must not be motivated by the desire to bring about a person's death.
- Considering the person's wishes, feelings, beliefs and values – especially any written statements made by the person when they had capacity.
- Taking into account the views of other people – take account of the views of family and informal carers and anyone with an interest in the person's welfare or appointed to act on the person's behalf.

- Taking into account of the views of any independent mental capacity advocate (IMCA) or any attorney appointed by the person or deputy appointed by the Court of Protection.
- Considering whether there is a less restrictive alternative or intervention that is in the person's best interests.

Other good practice points include:

- demonstrating that you have carefully assessed any conflicting evidence
- providing clear, objective reasons as to why you are acting in the person's best interests.

Marion said of her daughter Anna, who has multiple disabilities and no speech:

"Staff should accept that carers or other staff who know Anna well are the experts and they should utilise our knowledge of her communication system to assist them."

Eileen, who has been undergoing medical treatment in hospital, commented:

"If I was 'failing' I should want a professional to find out from my family (I have at the moment a husband and three daughters) what is important to me: what makes me happy, what makes me cross, what my interests are, what I can still do."

BOX 7

Example

Jo, who has severe brain damage, is looked after at home by her parents and attends a day centre for two days a week. The day centre workers are taking some of the service users riding at the local stables. Jo's parents want her to be included in activities at the centre but are anxious that she won't be able to manage a horse. Jo seems excited at the idea of going to the stables.

Her parents and staff discuss the situation and decide to ask a care assistant who has a good relationship with Jo and who can understand her communication to accompany her to the riding stables and keep an eye on her. Acting in a person's best interests can involve negotiating a compromise between different views and wishes.

4.2 Acts in connection with care and treatment (Mental Capacity Act, Section 5; Code of Practice, Chapter 6)

When carrying out acts of care and treatment in the best interests of a person who lacks capacity, staff will be legally protected. This means that staff will be protected under Section 5 of the MCA against legal challenges (but not if they act negligently), provided that they:

- have taken reasonable steps to assess the person's capacity to consent to the act in question
- reasonably believe that the person lacks the capacity to consent
- reasonably believe that the act they are carrying out is in the person's best interests.

However, staff will not be protected if they act negligently.

Acts in connection with personal care may include:

- assistance with physical care, e.g. washing, dressing, toileting, changing a catheter and colostomy care
- help with eating and drinking
- help with travelling
- shopping
- paying bills
- household maintenance
- those relating to community care services.

Acts connected to healthcare and treatment may include:

- administering medication
- diabetes injections
- diagnostic examinations and tests
- medical and dental treatment
- nursing care
- emergency procedures.

You must also consider whether you could provide the care or treatment in a less restrictive way – for example, could a person be given a shower that they can manage themselves rather than a bath for which they will need to be supervised? The three conditions described above must also be met. What are these conditions?

The decision maker must:

- **have taken reasonable steps to assess the person's capacity to consent to the act in question**
- **reasonably believe that the person lacks the capacity to consent**
- **reasonably believe that the act they are carrying out is in the person's best interests.**

4.3 Who is the decision maker in health and social care services?

The 'decision maker' is a shorthand term for someone who has to decide whether to provide care or treatment for someone who cannot consent because they lack the capacity to do so. The decision maker will vary depending on the individual's circumstances and the type of decision involved.

Social care staff will be decision makers for many day-to-day situations. They may also act as decision makers for longer-term decisions regarding the care of an individual who lacks capacity. Those making such decisions have some protection under the MCA (see Section 5 of the Act).

Health professionals will be decision makers for medical and related treatment, such as dental care and physiotherapy. 'Treatment' includes investigations such as X-rays, as well as procedures like operations and injections. However, doctors are unlikely to be decision makers for social activities or day-to-day care. Nurses will be the decision makers in relation to nursing care.

Remember, the person delivering the treatment or nursing care makes the decision about whether to deliver the care, even though the treatment may have been prescribed by someone else. Although decisions may result from discussions with other professionals or with the medical or nursing team, the person who delivers the treatment or care for somebody who lacks capacity is responsible for making the final decision to deliver that treatment or care in the person's best interests.

Family members and unpaid carers who live with or care for people who lack capacity to make decisions will often be the decision makers for many day-to-day acts such as what people eat or wear.

You may want to use case study 3 on best interests at this point. How would you record this decision and where?

At this point, you have:

- **identified instances of care and treatment where staff may act in the best interests of a person lacking capacity to consent**
- **been introduced to the process of establishing a person's best interests**
- **clarified the role of the decision maker**
- **learnt the key elements of consultation and engagement when establishing a person's best interests.**

5 Restraint

5.1 Limitations on restraint

(Mental Capacity Act, Sections 5 and 6; Code of Practice, 6.11–6.19)

In circumstances where restraint needs to be used, staff restraining a person who lacks capacity will be protected from liability (for example, criminal charges) if certain conditions are met. There are specific rules on the use of restraint, whether verbal or physical, and the restriction or deprivation of liberty, as outlined in the Code of Practice, 6.11–6.19 and 6.40–6.53 and Department of Health and Welsh Assembly Government guidelines (www.dh.gov.uk/assetRoot/04/06/84/61/04068461.pdf and <http://new.wales.gov.uk/docrepos/40382/40382313/childrenyoungpeople/childrenfirst/603793/framework-rpi-e.pdf?lang=en>).

If restraint is used, staff must reasonably believe that the person lacks capacity to consent to the act in question, that it needs to be done in their best interests and that restraint is necessary to protect the person from harm. It must also be a proportionate or reasonable response to the likelihood of the person suffering harm and the seriousness of that harm. Restraint can include physical restraint, restricting the person's freedom of movement and verbal warnings, but cannot extend to depriving someone of their liberty (the difference between restraint and deprivation of liberty is discussed in Part 5.2 of these materials).

Restraint may also be used under common law in circumstances where there is a risk that the person lacking capacity may harm someone else.

BOX 8

Example

Mandy, who has severe learning disabilities, likes to visit the nearby park but often wants to climb over the fence around the pond. Staff from the centre she attends generally avoid this by distracting her, but on occasion they do have to stop her climbing over the fence. They have shared their ideas about which distractions work best, but sometimes it is necessary to stop Mandy from potentially injuring herself or getting very distressed. They have a plan for restraining her in this situation which is recorded in her care plan.

If Mandy had an appointed attorney or deputy, staff might have to seek their permission for this plan.

Section 5 of the MCA, which provides protection from liability in certain circumstances, will not protect staff from liability for any action they take that conflicts with a decision made by someone acting under a Lasting Power of Attorney or a deputy appointed by the Court of Protection, whose authority extends to such decisions, nor does it protect staff against negligent acts. (For more information, see Chapter 6 of the Code of Practice).

5.2 The Bournewood Case

This is a legal case which tested the boundary between appropriate restraint or restriction and the loss of human rights under Article 5 of the European Convention on Human Rights (ECHR) – the right to liberty. The Government is seeking to amend the MCA to take into account the issues raised by this case.

The patient was in hospital and lacked the capacity to say whether he would stay in hospital and accept treatment. He was not detained under the Mental Health Act 1983.

The European Court of Human Rights determined that:

“The key factor in the present case [is] that the health care professionals treating and managing the applicant exercised complete and effective control over his care and movements.”

The Court found that:

“The concrete situation was that the applicant was under continuous supervision and control and was not free to leave.”

The distinction between restraint and the loss of liberty, which took this case to the European Court, is *“one of degree and intensity, not one of nature and substance”*. Any deprivation of liberty can only be lawful if accompanied by safeguards similar to those surrounding detention under the Mental Health Act 1983.

The Department of Health (December 2004) and the Welsh Assembly Government (January 2005) have issued guidance and a briefing sheet, which should already be included in service providers' policies. At the time of writing, the Government is taking legislation through Parliament to establish a new set of safeguards in the MCA for people who need to be deprived of their liberty in their best interests and who cannot make the necessary decisions for themselves.

At this point, you have:

- **confirmed that restraint may only be used in limited circumstances**
- **learnt that the use of restraint must always be recorded**
- **been alerted to the Bournewood Case and the need to seek advice in such circumstances.**

6 Lasting Powers of Attorney

(Mental Capacity Act, Sections 9–14; Code of Practice, Chapter 7)

6.1 What is a Lasting Power of Attorney?

Under a Lasting Power of Attorney (LPA) an individual can, while they still have capacity, appoint another person to make decisions on their behalf about financial, welfare or healthcare matters. The person making the LPA chooses who will be their attorney. They can give power to the attorney to make all decisions or they can choose which decisions they can make. LPAs replace Enduring Powers of Attorney (EPAs) (made under the Enduring Power of Attorney Act 1985). Guidance on LPAs can be found at: www.guardianship.gov.uk or www.publicguardian.gov.uk (from October 2007).

When acting under an LPA, an attorney has the authority to make decisions on behalf of the person who made it if they can no longer make these decisions for themselves. In these cases, an attorney is not there simply to be consulted (although they should still be consulted if appropriate where other decisions are being made). Attorneys must act in accordance with the Code of Practice.

Isabel is in her eighties and has been a service user and a carer. She commented:

"I made my daughter responsible for me ... because I realised how important it was. I trust her implicitly."

There are two different forms of LPA. People can choose one or both. These are:

- personal welfare, including healthcare
- property and affairs (financial matters).

The person making the LPA is the **donor**, who donates or hands over responsibility to make decisions under specified circumstances. The person appointed to make the decisions under the LPA is the donee, also known as the **attorney**. There are some restrictions depending on the type of LPA; for example, there are restrictions on gifts (see Part 6.4 of these materials). One attorney may hold a number of LPAs for different people; for example, a daughter can have LPAs for both her parents. A bank official can have LPAs for a number of clients. A person can choose one or a number of people to hold their LPA, such as a partner and adult children.

If a personal welfare LPA is in place but does not include the authority to make the decisions which now need to be made, health and social care staff will make the necessary best interests decisions, but they should consult with the attorney.

6.2 When is an LPA valid? (Mental Capacity Act, Section 9)

In order to be valid, an LPA must be set out on the right form and registered with the Office of the Public Guardian before it can be used. An LPA is a formal, legal document. A personal welfare LPA will only take effect when a person has lost capacity to make a particular decision. If it is not registered with the Office of the Public Guardian, it cannot be used. An LPA concerning financial matters will take effect immediately it is registered, unless the donor specifies that it should not take effect until they lose capacity to make these decisions.

6.3 Who can be an attorney?

It is up to the donor to choose whom they wish to appoint as their attorney. An attorney could be a family member or a friend, or a professional such as a lawyer. The Code of Practice advises that health and social care staff should not act as attorneys for people they are supporting unless they are also close relatives of the person who lacks capacity. Attorneys, like everyone else, are always subject to the provisions of the Mental Capacity Act (MCA), particularly the core principles and the best interests requirements.

An attorney must be over 18 years old and must not be bankrupt (for property and affairs LPAs only). Most attorneys will be named individuals. However, for property and affairs LPAs, the attorney could be a trust or part of a bank.

BOX 9

Example

(Code of Practice, 7.30–7.31)

Mrs Rahman has never trusted doctors and prefers to rely on alternative therapies. She saw her father suffer after invasive treatment for cancer. She is clear that she would refuse such treatment even if she might die without it.

Mrs Rahman is diagnosed with cancer and discusses her wishes with her husband. She trusts her husband to respect her wishes about the form of treatment she would, or would not, accept. She asks him to act as her attorney to make health and welfare decisions on her behalf should she lack the capacity in the future.

Mrs Rahman makes a personal welfare LPA, appointing her husband to make all her welfare decisions, including the authorisation to refuse life-sustaining treatment, on her behalf.

If his wife loses capacity to make her own decisions, Mr Rahman will be able to make decisions about treatment in her best interests, once the LPA is registered, taking into account what he knows about her feelings.

6.4 Powers of and limitations on LPAs

An LPA can be used to set out a person's wishes and preferences, which an attorney must then take into account when determining the person's best interests. For example, a person may want their attorney to take their religious beliefs into account when making decisions for them in the future. However, it is important to remember that an attorney can consent to or refuse treatment as specified by the donor in the LPA, but an attorney has no power to demand a specific treatment that healthcare professionals do not believe is clinically necessary or appropriate.

If the donor has not specified any limits to the attorney's authority, the attorney will be able to make all decisions on their behalf. However, they will only be able to refuse life-sustaining treatment if this has been specified in the LPA.

An attorney acting under a property and affairs LPA can only make certain gifts from the property and estate of the donor, for example to friends and relatives (including the attorney themselves), and on customary occasions such as birthdays, Christmas, Divali or any other religious festival the person lacking capacity would be likely to celebrate. Any customary gift or charitable donation must be reasonable in the circumstances. Limitations may also be specified in the LPA. The Court of Protection can give an attorney permission to make additional gifts if the attorney seeks the Court's approval.

6.5 Enduring Powers of Attorney **(Mental Capacity Act, Schedule 4; Code of Practice, Chapter 7)**

Enduring Powers of Attorney (EPAs) were established by the Enduring Powers of Attorney Act 1985. They allow the appointed attorney to manage property and financial affairs on behalf of the donor. At the onset of the donor's incapacity, the attorney must register the EPA with the Office of the Public Guardian in order for their authorisation under the EPA to continue. No new EPAs can be set up after the MCA is implemented, but existing EPAs will continue to be valid whether registered or not (Code of Practice, Chapter 7). Donors can choose to replace their existing EPA with an LPA if they still have capacity.

At this point, you have:

- **learnt when an LPA is valid**
- **identified who can be an attorney**
- **discovered that LPAs can be used for a variety of decisions but can't be used to demand specific care or treatment**
- **confirmed that existing EPAs will continue to be valid.**

7 Resolving disputes

(Code of Practice, 5.63–5.64)

The Code of Practice is clear that any dispute about the best interests of a person who lacks capacity should be resolved, wherever possible, in a quick and cost-effective manner. Alternative solutions to disputes should be considered, where appropriate, before any application to the Court of Protection. The Court will consider if appropriate alternatives have been pursued when an application is made. Certain groups, including people who lack or are said to lack capacity to make a decision, have an automatic right of application to the Court. Otherwise, the Court will decide which applications it will accept.

Alternative methods for resolving disputes include the following:

- Disputes or arguments between family members may be dealt with informally or through mediation.
- Disputes about health, social or other welfare services may be dealt with by informal or formal complaints processes such as Patient Advice and Liaison Services (PALS) in the NHS in England or through other existing complaints systems.
- Advocacy services may be able to help resolve a dispute.

Disputes regarding certain medical treatments may go directly to the Court of Protection; see the example in Box 10.

At this point, you have:

- **learnt that the Court of Protection has a role in resolving disputes, but this may be only after alternative solutions have failed**
- **identified possible alternative solutions to dispute resolution such as mediation, PALS or advocacy services.**

8 The Court of Protection and deputies

(Mental Capacity Act, Part 2; Code of Practice, Chapter 8)

8.1 What is the Court of Protection?

The Court of Protection is a specialist court with powers to deal with matters affecting adults who may lack capacity to make particular decisions. The Court is able to hear cases at a number of locations in England and Wales. It covers all areas of decision making under the Mental Capacity Act (MCA) and can determine whether a person has capacity in relation to a particular decision, whether a proposed action would be lawful, whether a particular act or decision is in a person's best interests and the meaning or effect of a Lasting Power of Attorney (LPA) in disputed cases.

The Court of Protection plans to be an accessible, regional court. It aims to be informal and quick. It takes over the duties of the former Court of Protection and matters regarding healthcare and personal welfare that were previously dealt with by the High Court. The Court charges a fee for applications – information on fees and forms are available on the Public Guardianship Office website.

It is expected that the Court of Protection will only be involved where particularly complex decisions or difficult disputes are involved.

Either the Court of Protection or the Family Court may deal with health and welfare decisions concerning 16 and 17-year-olds who lack capacity to make particular decisions (see Part 13 of these materials).

BOX 10

Example

(Code of Practice, 8.3 and 8.17)

Michael has been diagnosed with a rare disease. His prognosis is poor. His family and healthcare staff have become aware of a new treatment which is reported to produce improvements in some patients but it has side effects.

Michael lacks capacity to consent to the treatment. The consultant, who is the decision maker regarding Michael's treatment, wants to use this treatment but Michael's family are unhappy about the side effects and believe that treatment would not be in Michael's best interests. Because of the difference in opinion, an application is made to the Court of Protection for a declaration that it would be lawful, and in Michael's best interests, to receive the treatment. The Court, after considering evidence from all relevant parties, makes such a declaration and Michael receives the treatment.

8.2 What is a court-appointed deputy?
(Mental Capacity Act, Section 16(4)(a))

The MCA requires the Court to make a decision where possible. However, the Court might decide that it is appropriate to appoint a deputy. Deputies are appointed by the Court of Protection to make ongoing decisions on behalf of a person who lacks capacity to make those decisions.

A deputy can be appointed to deal with financial matters and/or personal welfare. The appointment of a deputy could take place, for example, where no Lasting Power of Attorney exists or there is a serious dispute among carers that cannot be resolved in any other way. The appointment of a deputy is limited in scope (what it can do) and duration (time). This is to reflect the principle of the less restrictive intervention.

A deputy can be a family member, or any other person (or in property and affairs cases, a trust) the Court thinks suitable.

A deputy must act with regard to the Code of Practice, in accordance with the Act's principles and in the person's best interests.

At this point, you have:

- **clarified the role of the Court of Protection**
- **been alerted to the role of court-appointed deputies.**

9 Advance decisions to refuse treatment

(Mental Capacity Act, Sections 24–27; Code of Practice, Chapter 9)

9.1 Advance decisions

The Mental Capacity Act (MCA) requires that advance decisions are made in a particular way. It is essential that professionals involved in the care of a person who lacks capacity understand the difference between an **advance decision** to refuse treatment and other expressions of an individual's wishes and preferences.

An advance decision to refuse treatment enables an adult to make treatment decisions in the event of their losing their capacity at some time in the future. Such a decision properly made is as valid as a contemporaneous decision (made at the time) and so it must be followed, even if it would result in the person's death. If an advance decision involves refusing life-sustaining treatment, it has to be put in writing, signed and witnessed but, otherwise, advance decisions can be verbal and do not need to be signed or witnessed if they are written down.

Even in the absence of an advance decision, people's views and wishes, whether written down or not, should be used to assist in planning appropriate care for the individual and making decisions in their best interests. Such statements of wishes and feelings are important, particularly if they are written down, but are not legally binding in the same way as advance decisions.

BOX 11

Example

Michaela, aged 74, is partially paralysed following a stroke and is treated in hospital following operations for a fracture. A nurse applies a vacuum dressing to the wound but Michaela finds it painful and uncomfortable and asks the nurse not to use it again under any circumstances. This request is noted in Michaela's notes. Michaela is treated in hospital again a year later following another stroke when her operation scars are again a problem. On this admission, she is very confused and is not able to communicate clearly with staff. She is assessed as lacking capacity to consent to treatment. The doctor on duty suggests that a vacuum dressing be applied. However, the nurse notes from Michaela's records that she has said in the past that she does not want this treatment ever again. This is an advance decision that must be followed as Michaela had capacity to make the advance decision at the time it was made.

Karen, who has severe physical disabilities, felt that advance decisions could be used even more widely in the future:

"I think everyone should have an advance decision regardless of impairment or even if you've not got an impairment. And I think it's really important for people to talk about it and I think that a very important part of this Act is that people start to talk about it, because people don't."

Jenny, a mental health service user, said:

"In terms of advance decision, where someone's anticipating that at some point they're going to lack capacity, I think that's a really good thing. Because you often get situations where people verbally express what their wishes are to relatives or carers, or people who have an emotional attachment and then, if they're in a situation where they lack capacity, that person's not necessarily able to make a decision in the best interests for them because they are too emotionally involved. And so, if someone can put something in writing beforehand and make sure that that is followed, then it's essentially a good idea, it's a really good thing."

9.2 When are advance decisions valid and applicable? (Code of Practice, 9.40)

An advance decision is valid when:

- it is made when the person has capacity
- the person making it has not withdrawn it
- the advance decision is not overridden by a later Lasting Power of Attorney that relates to the treatment specified in the advance decision
- the person has acted in a way that is consistent with the advance decision.

An advance decision is applicable when:

- the person who made it does not have the capacity to consent to or refuse the treatment in question
- it refers specifically to the treatment in question
- the circumstances the refusal of treatment refers to are present.

An advance decision to refuse life-sustaining treatment is applicable when:

- it is in writing, including being written on the person's behalf or recorded in their medical notes
- it is signed by the person making it (or on their behalf at their direction if they are unable to sign) in the presence of a witness who has also signed it
- it is clearly stated, either in the advance decision or in a separate statement (which must be signed and witnessed), that the advance decision is to apply to the specified treatment, even if life is at risk.

But an advance decision is not applicable if there are reasonable grounds for believing that circumstances now exist that the person did not anticipate at the time they made the advance decision and which would have affected their decision had they been able to anticipate them (e.g. new treatment), or if they have behaved in a way that raises doubts about or contradicts their advance decision.

Staff must be able to recognise when an advance decision to refuse treatment is both valid and applicable. A best interests decision to provide treatment cannot override a valid and applicable advance decision that refuses that treatment. Protection from liability will not apply if a valid and applicable advance decision is ignored.

The decision of an attorney acting under a registered Lasting Power of Attorney will override an advance decision if the Lasting Power of Attorney has been made after the decision and gives the attorney the right to consent to or refuse the treatment specified. There are special rules for people who are detained under the Mental Health Act 1983; in some circumstances, their refusal of treatment for a mental disorder may be overridden (see Mental Capacity Act 2005: Mental Health Training Set).

Advance decisions may not be valid if the individual made the decision while they had capacity and if they then did something that is clearly inconsistent with the advance decision – see the example of Sam in Box 12.

BOX 12

Examples

(Code of Practice, 9.1 and 9.40)

1. Mari met with her solicitor to draw up her will and make arrangements for what she wanted to happen to her should she get an illness such as dementia. She had been shaken by what had happened to her sister during her last days in hospital and she wanted those caring for her to know that if she had a problem such as dementia, which meant that she lacked the capacity to consent to or refuse life-sustaining treatment, then she did not want to be resuscitated. She had tried to talk to her family about this but they found it morbid to talk about such things. She made an advance decision refusing resuscitation even if her life was at risk, which was written down, signed and witnessed by her neighbour. She told her family where it was kept, leaving copies with her GP and her solicitor.

Mari's wishes were respected and her family found it very helpful to have a clear idea of what she wanted. Healthcare staff were required to follow her advance decision regardless of family members' views or wishes so there was no conflict when the question of resuscitation arose.

2. Sam made a signed and witnessed advance decision to refuse any treatment to keep him alive by artificial means. A few years later, he is injured in a rugby accident and is paralysed from the neck down and only able to breathe with artificial ventilation. Initially, he is conscious and able to agree to treatment. He participates in a rehabilitation programme. Some months later, he loses consciousness.

His advance decision is found although he had never mentioned it. His previous consent to treatment and participation in rehabilitation raise questions about the validity of the advance decision, as it is inconsistent with his actions prior to his lack of capacity. So those making treatment decisions on his behalf decide that his recent actions in agreeing to treatment and participating in rehabilitation place doubt on the validity of his advance decision and continue to treat him (such decisions must be made on a case-by-case basis and must take all relevant evidence into account).

As part of empowering service users, staff need to develop means of promoting, implementing and recording this form of advance planning. NHS trusts and user groups are developing guidance on the use of advance decisions and expressions of wishes.

The BMA published its 3rd Edition of "Withholding and Withdrawing Life-prolonging Medical Treatment: Guidance for decision making" in March 2007.

You could consider case study 4 on advance decisions to refuse treatment at this point.

At this point, you have:

- **identified when an advance decision is valid and applicable**
- **discovered that a valid advance decision to refuse life-sustaining treatment must be in writing, signed and witnessed.**

10 Independent mental capacity advocates

(Mental Capacity Act, Sections 35–41; Code of Practice, Chapter 10)

The Mental Capacity Act (MCA) introduces a duty on the NHS and local authorities to involve an **independent mental capacity advocate (IMCA)** in certain decisions. This ensures that, when a person who lacks capacity to make a decision has no one who can speak for them and serious medical treatment or a move into accommodation arranged by the local authority or NHS body (following an assessment under the NHS and Community Care Act 1990) is being considered, an IMCA is instructed.

The IMCA has a specific role to play in supporting and representing a person who lacks capacity to make the decision in question. They are only able to act for people whose care or treatment is arranged by a local authority or the NHS. They have the right to information about an individual, so they can see relevant health and social care records.

The duties of an IMCA are to:

- support the person who lacks capacity and represent their views and interests to the decision maker
- obtain and evaluate information, both through interviewing the person and through examining relevant records and documents
- obtain the views of professionals and paid workers providing care or treatment for the person who lacks capacity
- identify alternative courses of action
- obtain a further medical opinion, if required
- prepare a report (that the decision maker must consider).

In England, regulations have extended the role of IMCAs so they may also be asked to represent the person lacking capacity where there is an allegation of or evidence of abuse or neglect to or by a person who lacks capacity. In adult protection cases, an IMCA can be appointed even though the person has family or friends.

Similarly, the regulations also allow IMCAs to contribute to reviews for people who have been in accommodation arranged by the local authority or NHS body or who have been in hospital for more than 12 weeks and who have nobody else to represent them.

The local authority or NHS body may instruct an IMCA to represent the person lacking capacity in either adult protection cases or accommodation reviews if they consider that it would be of 'particular benefit' to the person.

The National Assembly for Wales has also extended the role of IMCAs in Wales, to cover accommodation reviews and adult protection cases.

BOX 13**IMCAs always represent the interests of:**

- those who have been assessed as lacking capacity to make a major decision about serious medical treatment or a longer-term accommodation move, if they have no one else to speak for them other than paid carers, and if their care or accommodation is arranged by their local authority or NHS.

IMCAs may represent the interests of:

- those who have been placed in accommodation by the NHS or local authority, and whose accommodation arrangements are being reviewed, and/or
- those who have been or are alleged to have been abused or neglected or where a person lacking capacity has been alleged or proven to be an abuser (even if they have friends or family).

An IMCA is not a decision maker for the person who lacks capacity. They are there to support and represent that person and to ensure that decision making for people who lack capacity is done appropriately and in accordance with the MCA.

In England, the local authority area where a person currently is (e.g. in hospital) is responsible for making the IMCA service available. In Wales, local health boards have this responsibility. If the decision is about treatment, the relevant NHS body must instruct an IMCA, if it is about a move it will be either the local authority or the NHS body.

To contact an IMCA, look for details on the IMCA website.

Karen, who has severe physical disabilities, said that she would value this independent status:

“They would have to be independent from the medical profession ...”

At this point you have:

- **noted that there is a duty to instruct an IMCA in certain circumstances**
- **identified who an IMCA can represent**
- **noted that an IMCA is not a decision maker**
- **confirmed that the local authority or local health board where the person is currently living is responsible for commissioning the IMCA service**
- **identified who instructs an IMCA**
- **noted that the IMCA’s report must be considered.**

11 Research

(Mental Capacity Act, Sections 30–34; Code of Practice, Chapter 11)

There are clear rules about involving people in health and social care research studies when they are not able to consent to taking part. A family member or carer (**the consultee**) should be consulted about any proposed study. People who can be consultees include family members, carers, attorneys and deputies, as long as they are not paid to look after the person in question and their interest in the welfare of the person is not a professional one. If they say that the person who lacks capacity would not have wanted to take part, or to continue to take part, then this means that the research must not go ahead.

If there is no such person who can be consulted, the researcher must find someone who is not connected with the research who can fulfil this role instead. Guidance will be available to researchers about how to go about this. Again, if the consultee says that the person would not have wanted to take part or continue to take part, the research must not go ahead.

The research has to be approved by the relevant research ethics committee. A researcher must stop the research if at any time they think that one of the MCA s31 requirements is not met (i.e. the research must relate to an impairing condition, have potential to benefit the person lacking capacity or be intended to provide knowledge about the same or a similar condition). This means that the researcher needs to understand the basis on which the research approval is given and ensure not only that the research is approved but that these requirements continue to be met throughout the period of the research. It is good practice for staff to ask to see evidence that the research has received approval.

If the person who lacks capacity appears to be unhappy with any of the activities involved in the research, then the research must stop.

NB: There are separate rules for clinical trials.

At this point, you have:

- **established that research can go ahead if it has approval from a relevant research ethics committee**
- **noted that if the individual appears unhappy with any aspects of the research, it must stop**
- **confirmed that if a consultee says the research must not go ahead because the person would have objected, then the research cannot proceed.**

12 Protection

(Code of Practice, Chapter 14)

12.1 Protecting vulnerable adults

Chapter 14 of the Code describes the way in which staff and people acting with formal powers under the Mental Capacity Act (MCA), i.e. attorneys and deputies, need to work with agencies responsible for the protection of vulnerable adults who lack capacity to make relevant decisions for themselves. Under the *No Secrets* guidance in England and *In Safe Hands* in Wales, the local authority is the lead agency, but all health and social care organisations are required to work collaboratively to promote the rights and protection of vulnerable adults. All health and care organisations should have their own adult protection policies and procedures. The implications of the MCA and the roles of attorneys and deputies, independent mental capacity advocates (IMCAs) and the Court of Protection need to be incorporated into these policies at local level.

12.2 New criminal offences of ill-treatment or wilful neglect *(Mental Capacity Act, Section 44; Code of Practice, Chapter 14)*

The MCA creates new criminal offences of ill-treatment or wilful neglect, which may apply to the following:

- people who have the care of a person who lacks capacity
- an attorney acting under a Lasting Power of Attorney or Enduring Power of Attorney
- a deputy appointed by the Court.

Allegations of offences may be made to the police or the Office of the Public Guardian. They can also be dealt with under adult protection procedures (via adult services in social services departments). The penalty for these criminal offences may be a fine and/or a sentence of imprisonment for up to five years.

Isabel is in her eighties and has been a service user and a carer. She commented:

"I was pleased to see that the Act introduces a new criminal offence of ill-treatment or neglect of a person. I'm so pleased to see that within the Act because we've found it very difficult to pinpoint how some retribution can take place and this makes it a criminal offence. It's a step forward."

BOX 14**Example**

Mabel is 90 and has dementia. She lives with her son, Steven, who is her main carer and welfare attorney under a Lasting Power of Attorney. A community nurse regularly visits Mabel to assist with dressings. She is concerned that Mabel is always cold and hungry. She suspects that Steven is neglecting his mother.

The nurse alerts her manager and they contact the police and the local adult protection service. A police investigation is carried out and Steven is charged with the wilful neglect of his mother. An IMCA is instructed to speak for Mabel, because her son, who would otherwise represent her, is possibly involved in the neglect. In addition, the Court, in conjunction with the Public Guardian, also takes steps to terminate the Lasting Power of Attorney. Adult services (social services) are alerted and alternative care arrangements for Mabel are put in place.

12.3 The Public Guardian

The MCA creates a new public office – the Public Guardian – with a range of functions that contribute to the protection of people who lack capacity. These functions include:

- keeping a register of Lasting Powers of Attorney and Enduring Powers of Attorney
- monitoring attorneys
- receiving reports from attorneys and deputies
- keeping a register of orders appointing deputies
- supervising deputies appointed by the Court
- directing Court of Protection visitors
- providing reports to the Court
- dealing with enquiries and complaints about the way deputies or attorneys use their powers (see the example in Box 14)
- working closely with other agencies to prevent abuse.

12.4 Court of Protection visitors

These are individuals appointed by the Lord Chancellor who provide independent advice to the Court and the Public Guardian. They will have a role in the investigation of allegations of abuse of a person who lacks capacity. Their visits will include checks on the general well-being of a person who lacks capacity. They will also help and support attorneys and deputies.

Further information and guidance on their role and how to contact them will be provided by the Office of the Public Guardian as it becomes more established. These details are likely to be included in local adult protection policies and procedures.

At this point, you have:

- **been alerted to the new criminal offences of ill-treatment or wilful neglect**
- **been reminded of the need to refer to local adult protection procedures**
- **noted the roles of the Office of the Public Guardian and of Court of Protection visitors.**

13 Children and young people

(Code of Practice, Chapter 12)

13.1 Young people under the age of 16

The Mental Capacity Act (MCA) does not usually apply to children younger than 16 who do not have capacity. Generally, people with parental responsibility for such children can make decisions on their behalf under common law. However, the Court of Protection has powers to make decisions about the property and affairs of a person who is under 16 and lacks capacity within the meaning of the MCA (see Part 2.4 of these materials) if it is likely that the person will still lack capacity to make these types of decision when they are 18.

BOX 15

Example

(Code of Practice, Chapter 12)

Jermain was 9 when he was in an accident and sustained severe head injuries causing permanent brain damage. He was awarded a significant amount of money in damages in the personal injury claim taken by his parents on his behalf. Jermain is unlikely to recover sufficiently to have the capacity to be able to make financial decisions for himself when he reaches 18. The Court of Protection makes an order appointing Jermain's father as deputy to manage his financial affairs.

13.2 Young people aged 16 and 17

The MCA overlaps with provisions made under the Children Act 1989 in some areas. There are no absolute criteria for deciding which route to follow. An example of where the MCA would be used would be when it is in the interests of the young person that a parent, or in some cases someone independent of the family, is appointed as a deputy to make financial or welfare decisions.

This could apply when a young person has been awarded compensation and a solicitor is appointed as a property and affairs (financial) deputy to work with a care manager and/or family members to ensure that the award is suitably invested to provide for the young person's needs throughout their lifetime (see the example of Jermain in Box 15).

Another example would be where the Court of Protection is asked to make a best interests decision where there is a dispute between those with parental responsibility for a young person and those treating or caring for the young person and the dispute cannot be resolved in any other way.

Under the MCA, only people who have reached the age of 18 can make Lasting Powers of Attorney and advance decisions. While 16 and 17-year-olds who have capacity may give or refuse consent to treatment at the time it is offered, they cannot make advance decisions under the MCA. However, any views or preferences they express when they have capacity should be considered when making a best interests decision.

A 16 or 17-year-old who lacks capacity to consent can be treated under Section 5 of the MCA. The person providing care or treatment must follow the MCA's principles and act in a way that they reasonably believe to be in the young person's best interests. Parents, others with parental responsibility, or anyone else involved in the care of the young person should be consulted unless the young person does not want this or this would otherwise breach their right to confidentiality. Any known views of the young person should also be taken into account. If legal proceedings are required to resolve disputes about the care, treatment or welfare of the young person aged 16 or 17 who lacks capacity, these may be dealt with under the Children Act 1989 or the MCA.

BOX 16

Example

(Code of Practice, 12.7, 12.23–12.25)

Katy is 17 and has profound learning disabilities and lacks the capacity to decide where she should live. Her parents are divorcing and do not agree on where Katy should live. In this case, it may be appropriate for the Court of Protection to deal with the disputed issue. This is because an order made in the Court of Protection could continue into Katy's adulthood, whereas any orders made by the family court under the Children Act 1989 will expire on Katy's 18th birthday.

At this point, you have:

- confirmed that the MCA generally only applies to people aged 16 and over
- discovered that the Court of Protection can be involved in decisions about someone under 16 if they are likely to continue to lack capacity to make those decisions when they reach 18
- learnt that only people of 18 and over can make Lasting Powers of Attorney and advance decisions under the MCA
- clarified that a 16 or 17-year-old who lacks capacity can be treated under the MCA.

14 Sharing information

(Code of Practice, Chapter 16)

People making decisions on behalf of people who lack capacity will often need to share personal information about the person lacking capacity. This information is required to ensure that decision makers are acting in the best interests of the person lacking capacity.

When releasing information, the following questions must be considered:

- Is the person asking for the information acting on behalf of the person who lacks capacity?
- Is disclosure in the best interests of the person who lacks capacity?
- What kind of information is being requested?

Remember that access to personal information must be in accordance with the law. For example, the NHS Code of Practice on confidentiality provides the following guidance:

“Where the patient is incapacitated and unable to consent, information should only be disclosed in the patient's best interests, and then only as much information as is needed to support their care.”

Disclosure of, and access to, information is regulated by:

- the Data Protection Act 1998
- the common law duty of confidentiality
- professional codes of conduct
- the Human Rights Act 1998.

Attorneys with a Lasting Power of Attorney are entitled to as much information as if they were the person lacking capacity. Court of Protection visitors have a right of access to records, and independent mental capacity advocates (IMCAs) have a right of access to that part of a person's records relevant to the decision in question. Court of Protection deputies may have access to a person's records if the Court gives them that power.

At this point you have:

- **identified the questions to ask when sharing information**
- **noted that attorneys with Lasting Powers of Attorney are entitled to information.**

15 How will the Mental Capacity Act change practice?

Some expectations from users and carers

Jenny, a mental health service user, said:

"Staff need to be open-minded, fair, approachable and have excellent communication and interpersonal skills ... They definitely need to be person-centred, putting the person first, thinking of them as a person and not as the next case."

Karen, who has severe physical disabilities, said about staff:

"... you have to be able to listen, you have to try and be impartial, you have to realise: yes, you will have emotional responses – but it's not about your emotional responses, it's about finding a way of helping the person to express themselves, because otherwise you're not going to be able to give a valid opinion of somebody's capacity if you don't do all those things."

In conclusion, you have:

- learnt the key elements of the Mental Capacity Act 2005 (MCA)
- reflected on the implications for your own practice
- listened to the hopes and views of users and carers about the way in which the MCA will improve practice.

Glossary

Advance decision – allows an adult with capacity to set out a refusal of specified medical treatment in advance of the time when they might lack the capacity to refuse it if it is proposed. If life-sustaining treatment is being refused, the advance decision has to be in writing, signed and witnessed, and has to include a statement saying that it applies even if life is at risk.

Attorney – the person an individual chooses to manage their assets or make decisions under a Lasting Power of Attorney or Enduring Power of Attorney.

Best interests – the duty of decision makers to have regard to a wide range of factors when reaching a decision or carrying out an act on behalf of a person who lacks capacity.

Capacity – the ability to make a decision.

Contemporaneous – at the same time. Any person with capacity can refuse treatment at the time it is offered. An advance decision means accepting that what that person wanted some time ago is what they want now.

Court of Protection – where there is a dispute or challenge to a decision under the Mental Capacity Act, this Court decides on such matters as whether a person has capacity in relation to a particular decision, whether a proposed act would be lawful, and the meaning or effect of a Lasting Power of Attorney or Enduring Power of Attorney.

Court-appointed deputy – an individual or trust corporation appointed by the Court of Protection to make best interests decisions on behalf of an adult who lacks capacity to make particular decisions.

Decision maker – someone working in health or social care or a family member or unpaid carer who decides whether to provide care or treatment for someone who cannot consent; or an attorney or deputy who has the legal authority to make best interests decisions on behalf of someone who lacks the capacity to do so.

Donor – the person who makes a Lasting Power of Attorney to appoint a person to manage their assets or to make personal welfare decisions.

Enduring Power of Attorney (EPA) – a power of attorney to deal with property and financial affairs established by previous legislation. No new EPAs can be made after the Mental Capacity Act 2005 is implemented, but existing EPAs continue to be valid.

Independent mental capacity advocate (IMCA) – an advocate who has to be instructed when a person who lacks capacity to make specific decisions has no one else who can speak for them. They do not make decisions for people who

lack capacity, but support and represent them and ensure that major decisions regarding people who lack capacity are made appropriately and in accordance with the Mental Capacity Act.

Lasting Power of Attorney – a power under the Mental Capacity Act that allows an individual to appoint another person to act on their behalf in relation to certain decisions regarding their financial, welfare and healthcare matters.

Public Guardian – this official body registers Lasting Powers of Attorney and court-appointed deputies and investigates complaints about how an attorney under a Lasting Power of Attorney or a deputy is exercising their powers.

Useful sources and references

Further information is available in the training sets that accompany this material. Links to more information and reference to the Mental Capacity Act (MCA) and Code of Practice are included in the text where relevant.

The following list includes other articles or books that may be of interest.

- Department for Constitutional Affairs Range of material including the statutes and an easy read summary of the MCA available on the website www.dca.gov.uk/legal-policy/mental-capacity
- Department of Health website: www.dh.gov.uk/mentalcapacityact
- Welsh Assembly Government Guidance issued for Wales available on website: http://new.wales.gov.uk/topics/health/nhswales/healthservice/mental_health_services/mentalcapacityact/?lang=en
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Core materials – training case studies and exercises

Case study 1: Communication and consultation

Gita, aged 84, is rather deaf and uses a hearing aid. She is taken into hospital after a minor accident in her home. On arrival in hospital she doesn't respond much to the nurses' questions and is distressed.

After being given treatment for fairly minor injuries, to which she raises no objection, Gita is admitted for observation. She refuses medication and pain relief. The nurses note that she is confused and disorientated, and question whether she has the capacity to refuse medication. They arrange for a specialist nurse for the elderly to visit the ward the following day to assess Gita's capacity to refuse.

That evening, Gita's daughter visits the hospital. She realises that Gita doesn't have her hearing aid with her and hasn't been able to understand any questions. Gita initially told staff in the ambulance about her hearing aid but it was apparently lost. There was no note in the records of her hearing impairment.

Gita had made several attempts to communicate with staff during her treatment and admission. Each time, staff responded with attempts to reassure her but did not understand what she was trying to tell them.

From this case, what can you identify as good practice in assessing capacity to make decisions about treatment and care?

Answer:

Gita went willingly to hospital. Nurses responded to her immediate needs by washing her and treating her cuts and torn skin. She did not object to this. However, her confusion and distress after the accident led staff to question her capacity to consent to or refuse medication. Referral for assessment was appropriate as the staff were unable to communicate with Gita effectively. Consulting someone who knew Gita well was good practice and in this case resolved the difficulties of communication and concerns about capacity.

Case study 2: Assessing capacity

Jake was in a factory accident that caused a brain injury. He is a single man in his mid-30s. He has been recuperating in hospital and has made steady progress on recovering from his injuries. However, he is still confused, his speech is incomprehensible and he often wanders away from the ward.

The rehabilitation team has recommended that he is transferred to a specialist rehabilitation unit which is further away from his family. His family are concerned about the distance from their home to the unit. Jake has to be assessed to see if he has the capacity to agree to the transfer.

A range of tests is carried out including a semi-structured interview and a cognitive screening test with a psychologist. Information is collected from ward staff and family members.

Jake's responses show that he cannot focus on information supplied or on the interview for more than a couple of minutes. He cannot write or draw his responses when given materials to do so. Jake does not communicate any understanding of what has happened to him or show that he considers that he has a problem that requires further treatment.

Do you think that Jake has the capacity to agree to the transfer to the rehabilitation unit?

Do you think his capacity to make major decisions of this sort will remain the same?

What are the factors that must be considered in deciding what will happen to Jake?

Who is the decision maker?

Answer:

Jake does not have the capacity to agree to this move as, at present, he does not understand or retain the necessary information and cannot assess information about the transfer. Nor is he able to communicate his views. His capacity to make decisions of this nature should improve with time and he is more likely to improve at the specialist rehabilitation unit. Staff and family agree that Jake does not have the capacity to consent to the move. They are also agreed that it is in Jake's best interests to transfer to the rehabilitation unit. The whole process is written up and the decision is clearly noted. The rehabilitation unit also records the decision.

The doctor who decides that Jake needs to go to the rehabilitation unit is the decision maker in this case. In making the decision, the doctor takes into account Jake's best interests with regard to care and treatment. However, under the Mental Capacity Act, the family has clear rights to be consulted. If there were conflict, the Court of Protection might appoint a deputy if other forms of mediation were unsuccessful or not possible or, in more complex situations, if there were ongoing decisions to be made.

If Jake has no family and there is no other appropriate person to consult, an independent mental capacity advocate (IMCA) must be appointed to support and represent Jake and to make sure decisions are being made properly, as he is likely to spend more than 28 days in the rehabilitation unit.

Case study 3: Best interests

Sharon is 25 and has severe learning disabilities. She lives in a care home and is close to her mother who visits regularly. Sharon really enjoys her mother's visits and looks forward to them. Sharon's sister is very ill and needs a bone marrow transplant. Sharon lacks the capacity to agree to be a bone marrow donor.

What action do you think is in Sharon's best interests?

How do you decide?

What did you take into account?

Answer:

This is based on an actual case where the judge decided that Sharon could donate as it was to her emotional, psychological and social benefit. At a first glance, you might think that Sharon couldn't possibly benefit from the procedure, you might be concerned that the procedure would hurt or distress her, and it would be in her sister's interests, but not Sharon's.

However, the judge's decision was based on evidence that if Sharon's sister were to die this would have an adverse impact on Sharon's mother with whom she had a very close relationship. Also, the death of her other daughter would significantly affect Sharon's mother's ability to visit Sharon, which would have a very bad effect on Sharon. Sharon also had her own good relationship with her sister and the loss of that would be detrimental. Best interests go beyond what is in a person's best interests medically. Such serious and complex cases should be decided by the Court.

Case study 4: Advance decisions

Janice is in her 50s and has a severe and enduring mental illness. She has been admitted to a mental health hospital on a number of occasions. When she is well, Janice does not like to take medication of any kind. She has told her community psychiatric nurse (CPN) that all antidepressant drugs have harmful long-term effects and she does not wish to take them under any circumstances. She has also told her CPN that she wants to be treated with alternative/complementary medicine and talking therapies if she is admitted to hospital.

Janice becomes very depressed and is admitted as an informal or voluntary patient to a unit of the mental health trust where she has been treated before. Janice has made it clear previously that she only wants to use complementary medicine but in the past she has responded fairly well to the recommended antidepressant for her condition. The psychiatrist treating her considers that her depression is so severe that, at the present time, she lacks the capacity to make a decision about medication.

What might happen next?

Answer:

As Janice is **not** detained under the Mental Health Act (MHA) 1983, staff should be guided by the Mental Capacity Act in making decisions about her treatment. They need to consider whether her previous statement about refusing antidepressant medication is a valid and applicable advance decision. As long as Janice had the capacity to make this decision at the time she discussed it with her CPN, it will be valid. If the use of antidepressants can be defined as life-sustaining treatment, the advance decision would need to be written, signed and witnessed and include a statement saying that it applies even if life is at risk in order to be valid.

However, in this case it has not been written down and witnessed. Janice's decision to refuse antidepressants stands and should be followed as long as antidepressant treatment is not defined as life-saving.

Janice's statement that she wishes to be treated with complementary medicine is an expression of her wishes and feelings, which should be treated as important but is not legally binding.

NB: If Janice were to be detained under the MHA, it would take precedence in the treatment of her mental disorder and medication may be administered against her wishes, provided the rules in the MHA are followed.

Quick quiz

Answer yes or no to the following questions

1. Is there a 'best' way to assess capacity to make a decision?
2. Can a person's capacity to make a particular decision be affected by any of the following:
 - a. stroke
 - b. alcohol
 - c. fever
 - d. mental illness
 - e. drug misuse?
3. Does a person's capacity to make a particular decision always stay the same?
4. Can you tell a person's capacity to make a particular decision by the way they look?
5. Can you tell a person's capacity to make a decision by the way they behave?
6. Does the person who can act as an attorney under a Lasting Power of Attorney have to be a solicitor?
7. Can a valid and applicable advance decision to refuse life-saving treatment be ignored?
8. Can a social worker, on their own, decide if a person who lacks capacity to make a particular decision should be given medical treatment?
9. Is a decision maker, or informal carer, for a person who lacks capacity to make a decision entitled to every item of information about the person who lacks capacity?

Answers No to all but question 2, which is yes to all parts.

Answers

PowerPoint presentation

This PowerPoint presentation is designed to help trainers develop training packages for health and social care practitioners in England and Wales.

It is designed to be used as part of the Core Training Set. The slides provide a summarised overview of issues for health and social care staff raised by the Mental Capacity Act 2005 (MCA). More information and explanations are available in the rest of the set, alongside case studies to help promote good practice in the operation of the MCA.

1 What is the Mental Capacity Act 2005 (MCA)?

- Developed to bring together and integrate existing law
- Puts the needs and wishes of a person who lacks capacity at the centre of any decision-making process

Isabel is in her eighties and has been a service user and a carer.

She commented:

"I think it's probably the most vulnerable group in society that we are looking at in terms of people who lack mental capacity. So we are looking at people that our society as a whole must be judged by in terms of what care do we give, how do we measure their quality of life compared with the rest of citizens in our society."

2 Which staff will be affected by the MCA?

- People working in a professional capacity, e.g. doctors, nurses, dentists and social workers
- People who are paid to care or support, e.g. home care workers and care assistants
- Anyone who is a deputy appointed by the Court of Protection
- Anyone acting as an independent mental capacity advocate (IMCA)
- Anyone carrying out research involving people who may lack capacity

3 Who will be affected?

- Many people with the following:
 - dementia
 - learning disability (especially severe learning disability)
 - brain injury
 - severe mental illness
 - anyone planning for the future
 - temporary loss of capacity, for example because somebody is unconscious because of an accident or anaesthesia or because of alcohol or drugs

4 What is mental capacity?

- Mental capacity is the ability to make a decision
- Capacity can vary over time
- Capacity can vary depending on the decision to be made
- Physical conditions, such as location, can affect a person's capacity
- Staff must not assume a lack of capacity because of a person's age, physical appearance, condition or an aspect of their behaviour

5 The five core principles (Code of Practice, Chapter 2)

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 (doable) 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.
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 their 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.

6 What is lack of capacity?

- An individual lacks capacity if they are unable to make a particular decision
- This inability must be caused by an impairment or disturbance in the functioning of the mind or brain, whether temporary or permanent
- Capacity can vary over time and depends on the type of decision

7 What triggers an assessment?

Staff should start from a presumption of capacity then take into account:

- the person's behaviour
- their circumstances
- any concerns raised by other people

8 How is capacity assessed?

Factors to be considered include:

- general intellectual ability
- memory
- attention and concentration
- reasoning
- verbal comprehension and expression
- cultural influences
- social context

9 How to assess capacity (Code of Practice, 4.11–4.13)

- The two-stage test of capacity:
 - Is there an impairment of, or disturbance in, the functioning of the person's mind or brain?
 - If so, is the impairment or disturbance sufficient to cause the person to be unable to make that particular decision at the relevant time?
- Staff should always keep records of any assessment

10 Questions that must be considered when assessing capacity

Does the person have the ability to:

- understand the information?
- retain information related to the decision?
- use or assess the information while considering the decision?
- communicate the decision by any means?

11 Common law tests of capacity

- Making a will
- Making a gift
- Litigating
- Entering into a complex contract
- Entering into marriage

12 What kind of help could someone need to make a decision?

- Provide all relevant information
- Don't give more detail than required
- Include information on the consequences of making, or not making, the decision
- Provide information on options
- Consult with family and care staff on the best way to communicate
- Be aware of any cultural, ethnic or religious factors that may have a bearing
- Make the person feel at ease
- Try to choose the best time of day for the person
- Try to ensure that the effects of any medication or treatment are considered
- Take it easy – one decision at a time
- Don't rush
- Be prepared to try more than once

13 What kind of records will staff need? (Code of Practice, 4.60–4.62)

- Day-to-day – record and review, but elaborate records not required on every occasion about decisions/acts of care
- Professional records – record assessments of capacity
- Formal reports as required

14 Who can be a decision maker?

- Varies depending on the individual's circumstances and the type of care or treatment or decision being considered
- Health and social care staff, family and unpaid carers can be decision makers when decisions relate to carrying out an act on behalf of somebody who cannot consent
- The person delivering the care or treatment makes the decision about whether to deliver that care or treatment
- Section 5 of the MCA gives protection from liability

15 Best interests (Mental Capacity Act, Section 4; Code of Practice, 5.1–5.69)

- **Any decision or act must be in a person's best interests**
- When making decisions, staff should take account of the following:
 - equal consideration and non-discrimination
 - considering all relevant circumstances
 - regaining capacity
 - permitting and encouraging participation
 - special considerations for life-sustaining treatment
 - the person's wishes, feelings, beliefs and values
 - the views of other people

16 Acting lawfully in connection with care and treatment

- Section 5 of the MCA provides protection from liability provided that all the MCA requirements are met
- **Includes acts of:**
 - personal care
 - healthcare and treatment
- Physical restraint is only lawful if the requirements are met (*MCA, Sections 5 and 6; Code of Practice, paragraphs 6.11–6.19*).

17 The Bournemouth Case

- This tests the boundary between restraint and the loss of human rights under Article 5 of the European Convention on Human Rights (ECHR) – the right to liberty for people who do not have capacity
- Any deprivation of liberty is lawful only if there are safeguards such as the Mental Health Act 1983 or a court ruling
- **Get advice**

18 Lasting Powers of Attorney (Mental Capacity Act, Sections 9–14; Code of Practice, Chapter 7)

- Two different LPAs to cover a range of circumstances:
 - personal welfare (including healthcare)
 - property and affairs (finance)
- **Who can be an attorney?**
 - family
 - friend
 - professional, e.g. lawyer
- An attorney must be over 18 years old
- An individual can be an attorney for more than one person
- Staff should **not** normally act as attorneys

19 Enduring Powers of Attorney (Mental Capacity Act, Section 4; Code of Practice, Chapter 7)

- Established under previous legislation to manage property and financial affairs
- No new Enduring Powers of Attorney after the MCA is implemented
- Existing Enduring Powers of Attorney will be valid whether registered or not

20 The Court of Protection and the Public Guardian (Mental Capacity Act, Part 2; Code of Practice, Chapter 8)

The MCA introduces two new bodies:

- **the Court of Protection**
- **the Public Guardian**

21 What is a court-appointed deputy?

- A person appointed to make certain decisions on behalf of a person who lacks capacity to make those decisions
- Could be a family member, carer or any other person the Court thinks suitable including a trust

22 Court of Protection visitors

- Appointed to provide independent advice to the Court and the Public Guardian
- May be involved in the investigation of allegations of abuse – see local policies
- Make checks on the general well-being of people who lack capacity whose affairs are being dealt with by the Court of Protection

23 The role of the Public Guardian

- Keeps a register of Lasting Powers of Attorney and Enduring Powers of Attorney
- Monitors attorneys
- Receives reports from attorneys and deputies
- Keeps a register of orders appointing deputies
- Supervises deputies appointed by the Court
- Directs Court of Protection visitors
- Provides reports to the Court
- Deals with enquiries and complaints about the way deputies or attorneys use their powers
- Works closely with other agencies to prevent abuse

24 Advance decisions

- An **advance decision** is prepared when a person has capacity
- It is a decision to refuse specific treatment and is binding
- Other expressions of an individual's preferences are not binding but must be considered
- Staff must be able to recognise when an advance decision is valid
- An advance decision must be written, signed and witnessed if life-sustaining treatment is being refused
- A relevant Lasting Power of Attorney will override an advance decision if it is made after the decision
- An advance decision can be withdrawn:
 - by the individual while they have capacity, or
 - if the individual does something that is clearly inconsistent with the advance decision, or
 - by the decision maker if treatment is now available that was not available when the advance decision was made

25 Independent mental capacity advocates (IMCAs)

- IMCAs are a local service to represent the interests of:
 - people lacking capacity when making a serious decision about medical treatment or a move, and in some adult protection cases, and if
 - they have no one else to speak for them other than paid carers, and
 - their care is arranged by their local authority or NHS
- The IMCA has a right to information about the person who lacks capacity but is not a decision maker

26 Research

- A person who lacks capacity to consent to taking part in research may take part, but researchers need to consult their family or carer, attorney or deputy, and do what they say the person would have wanted
- Staff should:
 - make sure that the research has ethical approval
 - stop the research if the person seems unhappy

27 Adult protection

- Any adult lacking capacity can be considered a vulnerable adult
- Staff should follow the adult protection guidance in *No Secrets* (England) or *In Safe Hands* (Wales) and remember that:
 - the lead agency is the local authority
 - all agencies have policies and procedures covering adult protection

28 New criminal offences of ill-treatment or wilful neglect (Mental Capacity Act, Section 44; Code of Practice, Chapter 14)

New offences apply to:

- People who have the care of a person who lacks capacity
- An attorney under a Lasting Power of Attorney or Enduring Power of Attorney
- A deputy appointed by the Court

Criminal offences can result in a fine and/or a sentence of imprisonment of up to five years.

29 Children and young people

- The MCA applies to people who are 16 years old or older
- 16 or 17 year olds who lack capacity can be treated under the MCA – their parents should be consulted unless the young person does not wish this
- The Court of Protection can be involved in decisions for someone under 16 if they are likely to still lack capacity at 18
- People have to be 18 to make Lasting Powers of Attorney and advance decisions

30 How will the MCA change practice?

Jenny, a mental health service user, said:

"Staff definitely need to be person-centred, putting the person first, thinking of them as a person and not as the next case."

Karen, who has severe physical disabilities, said about staff:

"... you have to be able to listen, you have to try and be impartial, you have to realise: yes, you will have emotional responses – but it's not about your emotional responses, it's about finding a way of helping the person to express themselves, because otherwise you're not going to be able to give a valid opinion of somebody's capacity if you don't do all those things."

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