East Sussex Mental Capacity Multi-Agency Policy and Procedures

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Chapter 1: Introduction and policy

This policy and procedures provides guidance on the operation of the Mental Capacity Act (MCA) 2005. It is designed to be used by staff throughout the statutory and non-statutory health and social care services across East Sussex.

A number of Safeguarding Adults Reviews (SARs) carried out since 2015 have identified gaps in how the MCA is understood and applied in practice. Key learning has been identified in relation to:

- undertaking mental capacity assessments,
- effective multi-agency working,
- a need for increased use of advocacy support,
- best interests decision making,
- ensuring respectful challenge of decisions reached where necessary.

This guidance has been produced to support learning in the above areas, and should be used in conjunction with the MCA Code of Practice. Specifically, it seeks to provide advice and explanation as to:

- Why the policy is necessary (rationale).
- Whom it applies to, and where and when it should be applied (scope).
- The underlying beliefs upon which this policy is based (principles).
- The standards to be achieved (policy).
- How the policy standards will be met through working practices (procedure).

Throughout this document the Mental Capacity Act 2005 is referred to as the MCA.

Scope

This policy and procedures is for adoption, information and application by all staff of the partner agencies of the East Sussex Safeguarding Adults Board (SAB).

It does not replace any specific policies and procedures of partner agencies. Staff should also refer to relevant policies and guidance of their own organisation in conjunction with this document.

Chapter 2: Assessment and best interests decision making in practice

Introduction

The MCA Code of Practice outlines the process of enabling people to make decisions for themselves, and the process for formally assessing capacity where doubt exists about that person's ability to make a specific decision. Where a person is assessed to lack capacity, the MCA describes how we should approach the process of making a best interests decision. Whilst the process is fairly straightforward implementation of it in practice can be complex, for example, in situations where a person fluctuates in their ability to make decisions.

Mental capacity assessment flowchart

Remember! The assessment must be about the specific decision that needs to be made at a particular time. Delay the decision where the person's capacity may improve and the decision is not urgent.

Start from the assumption that the person has the mental capacity to make the specific decision that needs to be made.

If it appears the person has difficulty in making the decision consider carrying out a mental capacity assessment.

An assessment will usually involve the person's family, friends and carers.

If the person does not have family or friends to consult with a referral should be made for an Independent Mental Capacity Advocate (IMCA).

Mental capacity assessment

1. Is there a permanent or temporary impairment of, or disturbance in, the mind or brain?
2. If yes, is the person unable to make a decision in relation to the matter because of the impairment of, or a

Remember! Use all practicable steps to support the person with decision making, and maximise their participation.

The person is unable to make the decision if, after all appropriate help and support, they cannot:

1. understand relevant information about the decision and the consequences of making it, and / or
2. retain the information (only long enough to be able to make the decision), and / or
3. use and weigh up the information as part of the decision making process, and / or
4. communicate their decision by any means.

Person does not have mental capacity so make the decision in their best interests.

See: Best interests decision making flowchart.

Person is assessed to have mental capacity – respect their decision even if this seems to be unwise.

Note

If there is a valid Advance Decision to Refuse Treatment (ADRT) in place, the person's wishes should be respected.

If there is a Lasting Power of Attorney (LPA) with authority to make the decision, refer to that person for the best interests decision.

Best interests decision making flowchart

This process should be followed when a mental capacity assessment has confirmed that the person lacks mental capacity.

Anything done for, or on behalf of, the person who lacks capacity must be done in their best interests.

Should an Independent Mental Capacity Advocate (IMCA) be involved?

An IMCA must be involved if a decision about serious medical treatment or a long-term change of accommodation needs to be made, and the person has no family or friends with whom it is appropriate to consult.

Is a best interests meeting required?

A best interests meeting should be held where the decision is complex or controversial, or there is a dispute between the person, family members or other professionals.

Make the best interests decision

(See Best interests checklist)

Record decision making on relevant documentation, e.g. best interests decision making section of the mental capacity assessment or best interests meeting minutes.

Are there any disputes?

If a best interests decision is disputed, try to resolve locally, using the resolution process / complaints process where appropriate.

For some situations, it may be necessary to seek legal advice and refer to the Court of Protection.

Best interests checklist

Consider:

1. All relevant circumstances, and ensure the decision is not based on the person's age, appearance, behaviour or condition.
2. Whether the person is likely to regain capacity.
3. Encourage the person to participate in the decision making.
4. The person's past and present wishes and feelings (including any relevant written statement), and any beliefs and values that would be likely to influence the person's decision if he / she had capacity (e.g. cultural or religious background).
5. The views of others who are appropriate to consult.
6. The less restrictive options.
7. For life-sustaining treatment, that decisions are not motivated by a desire to bring about the person's death.

Note If the decision is urgent, there may not be time to examine all possible factors (MCA Code of Practice 5.13).

Support to make a decision

The process of decision making should be based on the five principles of the MCA and should, first and foremost, promote a person's autonomy and provide them with all 'practicable' and individualised support to help them reach a decision for themselves. Providing effective support with decision making at the outset can lead to resolving the situation at that point, and result in a mental capacity assessment no longer being required.

The MCA Code of Practice provides guidance on how this can be achieved. The additional points set out below are intended to complement this guidance.

- Delay the decision where a person's mental capacity may improve and the decision itself is not urgent.

- Provide support and undertake mental capacity assessments at a time when the person is at their highest level of functioning.

- Provide information in an appropriate format and use communication methods which the person is most familiar with, for example, using visual aids, memory aids or Makaton. This can be especially relevant when a person does not communicate verbally.

- Hold the discussion in an environment in which the person is comfortable and familiar with.

- Consider whether having another person present, such as a friend or family member, would help the person. Consider whether there is a duty to provide an Independent Mental Capacity Advocate (IMCA) or independent advocate under the Care Act 2014. The consideration of support from another individual has to be balanced alongside professional judgement as to whether the individual involved may exert undue pressure or coercion (whether this is intentional or unintentional).

- Consider what help the person may require to learn about and understand the information relevant to the decision, and ensure that you have explained all information which is relevant to the decision. For example, does the person need to be taken to view different residential options?

- Consider if there is anything else you can do which might mean that the person would be able to make the decision. For example, supporting the person to access an intensive programme of education could assist him / her to gain capacity to make the specific decision themselves.

Clearly, in emergency situations, for example, where a person requires immediate medical attention and they are unconscious, urgent decisions will need to be made and actions taken in that person's best interests. In such situations, it may not be practical or appropriate to delay action whilst trying to support the person to make

a decision. However, it is important for staff to try to communicate with that person and keep them informed as to what is happening.

Assessing mental capacity

When should an assessment of mental capacity be undertaken?

The MCA is designed to empower and protect individuals who may be unable to make a decision because of an impairment or disturbance in the mind or brain, such as through illness or disability, or the effects of drugs or alcohol.

The MCA makes clear that any assessment of capacity must be 'time and decision specific'. This means that:

- The assessment of capacity must be about the particular decision that has to be made at a particular time and is not about a range of decisions.
- If someone cannot make complex decisions, this does not mean that they cannot make other decisions. For example, someone may be able to make decisions about buying items to meet their everyday needs, but lack capacity to understand the consequences of not paying household bills.
- You cannot decide that someone lacks capacity based on their age, appearance, condition or behaviour alone.

If there is more than one decision to be made then a mental capacity assessment should be completed for each decision.

Who conducts mental capacity assessments?

The MCA Code of Practice is not prescriptive about who should assess capacity. Assessments should be undertaken by a worker with the appropriate level of competence to do so, based upon their knowledge and skills relevant to the needs of the adult. The assessor may not necessarily be the same person as the 'decision maker' who would be involved in reaching the best interests decision should the adult be assessed as lacking capacity (see section 'Best interests decision making').

Day-to-day decisions

Decisions which are covered by the MCA range from routine, day-to-day decisions (such as what to wear or eat) to more complex and significant decisions (such as where to live, receiving medical treatment or managing finances and / or property).

For most day-to-day decisions, the person who assesses capacity will be the individual directly concerned with the adult at the time, for example, the person caring for or supporting the person.

Significant decisions

The MCA Code of Practice states that 'more complex decisions are likely to need more formal assessments' (4.42) and will require a particular professional to lead the assessment.

Determining who should carry out capacity assessments in relation to more complex or major decisions depends on the nature of the decision being made. Decisions about serious medical treatment and therapeutic interventions should involve a doctor or relevant medical professional in the capacity assessment. A social care practitioner should carry out assessments relating to any plans for a change of accommodation, significant changes in the delivery of social care support, or in relation to safeguarding enquiries.

Joint capacity assessments

It is good practice for professionals to undertake joint capacity assessments in particularly complex cases. For example, a social worker may be the lead professional but the assessment may be enhanced by involvement from a psychologist. For significant financial decisions, such as appointing a Deputy, support with the capacity assessment from a solicitor or a representative from the Financial Services Team within Adult Social Care and Health (ASCH) may be helpful.

Joint capacity assessments help to provide:

- a broader range of experience and skills,
- a more comprehensive and holistic assessment,
- a more defendable judgement in court,
- continuous professional development for both practitioners,
- checks and balances within the assessment, and establishing a shared conclusion on the adult's capacity.

The two stage test of mental capacity

The MCA sets out a two stage test for determining capacity:

1. Does the person have an impairment of the mind or brain, or is there some sort of disturbance affecting the way their mind or brain works (whether temporary or permanent)? This is known as the diagnostic test.

2. If so, is the person's inability to make the decision at that time because of the identified impairment or disturbance? This is known as the functional test.

The functional test involves consideration of the person's ability to:

- **Understand the information relevant to the decision**

  Having identified the specific decision to be made, ask this question of the person during the assessment, in whatever manner is appropriate and record their answer. If it is not appropriate to ask the precise question, the reasons why it was not asked should be set out clearly.

  It is good practice to record the information and questions along with the person's responses or non-responses.

  It is not essential for the person to understand every element of what is being explained to them. What is important is that the person can understand the 'salient factors', i.e. the information that is directly relevant to the decision. The onus is on the assessor to identify the relevant information about the decision and what the options are that the person is to choose between.

- **Retain that information (long enough to make the decision)**

  The MCA sets out that capacity is the ability to make a decision 'at the material time' i.e. at the time of the assessment. If the person can retain enough information long enough during the assessment to reach the decision in hand, that is sufficient, even if the person cannot then retain the information for a longer period.

- **Use or weigh up the information as part of the decision making process**

  The mental capacity assessment should involve the person being presented with information regarding all realistic options relating to the decision, leading to a discussion around the benefits and burdens of each option. The use of a balance sheet approach can be helpful in recording these discussions.

  This aspect of the test has been described as the capacity actually to engage in the decision-making process itself and to be able to see the various parts of the argument and to relate the one to another.

  Care should be taken, as far as possible, not to conflate the way in which the person applies their own values and wishes (which may be very different from the assessor's) with a functional inability to use and weigh information.

- **Communicate their decision by whatever means**

  It is good practice to record the steps taken to facilitate effective communication in line with the manner in which the person usually communicates. This should include consideration of any communication aids, whether the person can use verbal communication or prefers writing things down, whether the person's communication is enhanced through the support of someone they know well, whether an interpreter is required etc.

Fluctuating capacity

Some people may have fluctuating capacity, i.e. they have a problem or condition which gets worse on occasions and affects their ability to make decisions. For example, someone with bi-polar disorder may have a phase in their condition which causes them to lack capacity to make financial decisions, leading to them getting into debt, even though at other times they are perfectly able to manage their money. This fluctuation can take place over days or weeks, or over the course of each day. There may be people whose cognitive abilities are significantly less impaired at the start of the day than they are towards the end. Where a person's capacity appears to fluctuate throughout the day, consideration should be given to identifying the optimal time of day to discuss the decision to be made and undertake a mental capacity assessment.

Other people may have a temporary impairment of their ability to make decisions due to an acute infection, which can cause confusion and / or delirium. The key question in these situations is whether the decision can wait, and if so you can work to treat or alleviate the cause of the temporary impairment and then support the person to reach a decision. If the decision cannot wait, then it is necessary to go ahead and assess the person's capacity and, if the person is assessed to lack capacity, to proceed with the best interests decision-making process.

Where a person has ongoing fluctuating capacity, the approach taken will depend upon the 'cycle' of the fluctuation in terms of both its length and severity, and also upon the nature of the decision. In such cases it may be necessary to review the capacity assessments over a period of time. It is good practice to seek legal advice in such complex cases.

Decisional and executive capacity

A common area of difficulty relates to the distinction between decisional and executive capacity. SCIE report 46 *Self-neglect and adult safeguarding: findings from research* highlights the difference between capacity to make a decision (decisional capacity) and capacity to actually carry out the decision (executive capacity). It can be very difficult in such cases to identify whether the person in fact lacks capacity.

Whilst it is not a requirement set out explicitly within the MCA, it is good practice to explore whether the person has capacity to act on a decision they have made, that is, whether they are able to understand and weigh up that there is a disparity between their ability to respond to questions in the abstract compared to their responses in the actual situation.

How should mental capacity assessments be recorded?

The recording of mental capacity assessments will vary, depending on whether the decision is routine or more complex, and many health and social care organisations will have their own templates and forms for practitioners to use.

Assessments regarding routine decisions can be recorded in appropriate documentation, such as medical notes, care plans, risk assessments or daily case notes.

Mental capacity assessments for more significant decisions will need to include more detailed and comprehensive information relating to the two stage test of capacity, using a suitable mental capacity assessment template.

However assessments are recorded, it is important to ensure that they are evidence-based. Good standards of recording within mental capacity assessments include the following considerations:

- Stating clearly the specific decision that is being assessed.
- Identifying the salient and relevant details the person needs to understand in relation to the decision.
- Ensuring that full details of all the options available to the person are set out.
- Demonstrating what steps were taken to promote the person's involvement and ability to decide.
- Evidencing each element of the assessment:
    1. What is the impairment or disturbance of the mind or brain? Is it temporary or permanent?
    2. How did the person demonstrate or fail to demonstrate that they were able to understand, retain, weigh-up and / or communicate their decision?
    3. How is their inability to reach a decision linked to the impairment or disturbance?
- Recording actual questions as they were asked, and factually recording the detailed responses given by the person and also any non-responses.

Recording yes / no answers without supporting detail are unlikely to provide sufficient evidence.

- Ensuring that professional opinion is distinguished from fact, and that opinions made are supported by factual evidence.

The role of the Independent Mental Capacity Advocate (IMCA)

In most situations, people who lack mental capacity will have a network of support from family members or friends who take an interest in their welfare, or from an appointed Deputy or Attorney. However, some people may not have anyone to support them (other than paid staff).

The MCA created the role of the IMCA to represent and support people who lack capacity.

The service is a legal right for people over 16 who:

- have been assessed to lack capacity to make specific decisions, and
- do not have an appropriate friend or family member to represent their views.

An IMCA must be involved if:

- the decision is about serious medical treatment provided by the NHS, or
- it is proposed that the person be moved into long-term care of more than 28 days in a hospital or eight weeks in a care home, or
- a long-term move (eight weeks or more) to different accommodation is being considered, for example, a move to a different care home.

Local authorities also have a power to involve IMCAs in other situations if they are satisfied that an IMCA would provide particular benefit. These situations include:

- care reviews about accommodation or changes to accommodation, and
- safeguarding enquiries.

In certain circumstances, a person who is subject to the Deprivation of Liberty Safeguards (DoLS) must have an IMCA instructed to support them. The IMCA will provide legal protection for people who may be deprived of their liberty (other than under the Mental Health Act 1983) where they are in a hospital or care home setting.

The duties of an IMCA are to:

- Support the person who lacks capacity and represent their views and interests.
- Obtain and evaluate information (an IMCA can talk to the adult in private and access copies of health and social care records, where necessary).
- As far as possible, ascertain the person's wishes and feelings, beliefs and values.
- Provide information to help work out what is in the person's best interests.
- Raise questions or challenge decisions which appear not to be in the best interests of the person.
- Seek a further professional opinion, if necessary.
- Prepare a report for the person who instructed them.

The IMCA Service in East Sussex is provided by POhWER. Please refer to their website for further information on the services they provide and how to make a referral.

https://www.pohwer.net/make-a-referral

Best interests decision making

Principle 4 of the MCA sets out that any action taken or decision made for, or on behalf of, a person must be made in his or her best interests if the person has been assessed as lacking mental capacity.

This is regardless of who the decision maker is and of the decision to be made.

The only exceptions to this are listed in Appendix 2.

Who is the decision maker?

Many different people may be required to make decisions on behalf of someone who lacks capacity to make decisions for themselves. The person making the decision is referred to as the 'decision maker'. Who the decision maker is will depend on the decision being made.

For most day-to-day decisions, the decision maker will often be the individual providing care and support to the adult at the time the decision needs to be made.

The table below outlines who is likely to be the decision maker in certain circumstances:

Decision	Decision maker
A change to care arrangements or change in accommodation.	Social worker / social care practitioner.
Medical treatment	Doctor / nurse / healthcare staff responsible for carrying out the treatment.
Health and welfare	A Lasting Power of Attorney (LPA) may be appointed for health and welfare decisions, and if so they would be the decision maker. If not, the relevant medical professional / social worker / health and social care practitioner.
Financial affairs	Enduring Power of Attorney (EPA) / LPA / Deputy, if in place. If not in place, a social care practitioner or solicitor may be the decision maker. **Note** If it is considered that an attorney is not acting in the person's best interests, the concerns can be reported to the Office of the Public Guardian to overrule the attorney's wishes; in these situations it may be necessary to involve the Court of Protection. Specific advice should be obtained through your legal services in these situations.
Legal transactions, such as making a will	A solicitor or legal practitioner must assess the person's capacity to instruct them. In cases of doubt, they should get an opinion from a relevant professional such as a doctor / psychiatrist / social worker / occupational therapist.
Serious decisions relating to care, accommodation, and / or health care and treatment which require specialist Court intervention e.g. in relation to a person who may be objecting to being under a Deprivation of Liberty Safeguards (DoLS) authorisation.	Court of Protection.

No matter who is making the decision, the most important aspect is that the decision maker aims to work out what would be in the best interests of the person who lacks capacity.

Informal carers

The MCA is relevant to anyone who has a relative or friend who may be unable to make some or all decisions for themselves, or who lack capacity to make routine, day-to-day decisions.

Anyone in a position where they might need to make a decision for someone who may lack capacity must decide whether that person is able to make that decision on their own.

If the person cannot make the decision, and there is no relevant Attorney or Deputy with the necessary authority to make the decision in question, the carer may become the decision maker.

Carers are not expected to be an expert in assessing capacity, but they should have a 'reasonable belief' that the person they care for lacks mental capacity to make certain decisions in certain situations e.g. day-to-day activities.

It should be noted that just because a person makes a different decision from the one the carer would make does not mean that the person lacks capacity to make that decision.

How does the decision maker decide what is in the person's best interests?

The MCA includes a statutory checklist of key factors that decision makers must consider when deciding what is in the best interests of the person who lacks capacity. This list is not exhaustive and further details are available in the MCA Code of Practice.

- It is important not to make assumptions about someone's best interests merely on the basis of the person's age or appearance, condition or any aspect of their behaviour.
- The decision maker must consider all the relevant circumstances relating to the decision in question.
- The decision maker must consider whether the person is likely to regain capacity (for example, after receiving medical treatment). If so, can the decision or act wait until then?

- The decision maker must involve the person as fully as possible in the decision that is being made on their behalf.

- The decision maker must in particular consider:

  - the person's past and present wishes and feelings (in particular if they have been written down), and

  - any beliefs and values (e.g., religious, cultural or moral) that would be likely to influence the decision in question, and

  - any other relevant factors.

- As far as possible the decision maker must consult other people if it is appropriate to do so, and take into account their views as to what would be in the best interests of the person lacking capacity, especially:

  - anyone previously named by the person lacking capacity as someone to be consulted,

  - carers, close relatives or close friends or anyone else interested in the person's welfare,

  - any Attorney appointed under a Lasting Power of Attorney, and

  - any Deputy appointed by the Court of Protection to make decisions for the person.

- Best interests decisions regarding life sustaining treatment, including the withdrawal of treatment and Do Not Attempt Resuscitation (DNAR) decisions, should not be influenced by a desire to bring about the person's death or conversely by a desire to sustain life for the benefit of others.

- When a decision is made on behalf of the person who lacks capacity to make that decision, the MCA states that options which are less restrictive of the person's basic rights and freedoms must be explored and considered fully.

Case study – considering less restrictive options

Mr Smith has Korsakoff syndrome and requires support with managing his finances. After problems with unpaid debts and potential eviction from his home, the Court of Protection has appointed the local authority as deputy for Mr Smith.

In considering all possible options for Mr Smith, the local authority decides that the least restrictive option for him would be to make arrangements to ensure that his essential bills are paid and arrange for him to have a restricted bank card that enables him to access a pre-determined amount of cash. This supports Mr Smith's independence within safe limits.

When does a best interests meeting need to be held?

Not all best interests decisions require a best interests meeting to be held e.g. when all parties involved are in agreement with the decision to be made.

A best interests meeting should be held when:

- the decision is complex or controversial,
- there is a range of options or issues that require the input of a number of different interested parties,
- there is disagreement or dispute between the decision maker and the person, members of the person's family or support network, or other professionals.

If the situation is urgent and action needs to be taken to safeguard a person immediately, it may not be possible to convene a best interests meeting before action is taken.

The 'doctrine of necessity' may be invoked in an emergency situation. That is, actions in a person's best interests can be made providing the professional reasonably believes the person lacks mental capacity and the proposed treatment or action is necessary to save their life or prevent a significant deterioration in their condition. In such situations, a mental capacity assessment should be undertaken and best interests meeting convened as soon as is practically possible, after the emergency action has been taken.

What is the purpose of a best interests meeting?

A best interests meeting provides an opportunity for all parties to state their opinions in a formal and transparent context. This can be important if the decision is challenged at a later date.

It is generally good practice that the person who chairs and co-ordinates the best interests meeting is not the decision maker. This can reduce the possibility of a conflict of interest. However, the decision maker needs to attend the meeting.

It is important to ensure that all relevant people are invited to attend the meeting, including:

- The person assessed as lacking capacity, wherever possible.
- Any involved family members or friends.
- The person responsible for implementing the decision.
- Key staff involved in the person's care.

- Any advocate or IMCA who is involved.
- Any professional who can contribute to the outcome of the best interests meeting.
- Anyone named by the person as someone to be consulted.
- Any Lasting Power of Attorney or court-appointed Deputy.

How should best interests decisions be recorded?

The recording of best interests decisions will vary across different agencies and organisations. Often there is a section within a mental capacity assessment form to record the best interests decision. If there is a formal best interests meeting the minutes should record the outcome and best interests decision reached.

It is good practice to consider using a balance sheet approach when recording best interests decision making. This helps to set out all the possible options available to the person along with the pros and cons of each option.

Whichever documentation is used, the record of the best interests decision should include:

- how the decision about what is in the person's best interests was reached,
- who was consulted to help work out the best interests decision,
- what the reasons were for reaching the decision,
- if the person has made a written statement and the decision maker does not follow this, the reasons for this should be specifically recorded.

Disagreements and disputes regarding mental capacity assessments and best interests decisions

Sometimes disagreements may arise relating to a person's capacity to make a decision and / or what is in their best interests. These differences of opinion can be with other professionals involved, the person or their family or friends.

Effective partnership working depends on an open and transparent approach and positive relationships, with an emphasis on working to resolve any disputes within the shortest time possible and to ensure the interests of the person concerned remain at the centre of the process.

If you are the decision maker you will need to clearly demonstrate in your record keeping that you have made a decision based on all available evidence and taken into account any conflicting views.

When a mental capacity assessment or best interests decision is challenged, resolution can be sought in the following ways:

- If the dispute relates to the outcome of a mental capacity assessment, the first step will always be to raise the matter with the person who completed the assessment via an appropriate level of management in that service.
- A second opinion from another professional may be helpful in some cases.
- Using an advocate independent of all parties involved. This could be in addition to an IMCA.
- Hold a multi-agency meeting to resolve the disagreement.
- Follow the East Sussex Safeguarding Adults Board Resolution Protocol (see Appendix 5).
- Consideration of local complaints procedures.
- Mediation can be useful in resolving some disagreements.
- There are some situations which may require a referral to the Court of Protection, particularly for disagreements that cannot be resolved in any other way.

For further guidance which sets out the different options for settling disagreements refer to chapter 15 of the MCA Code of Practice.

Chapter 3: Restraint

The MCA defines restraint as the use or threat of force or medication to make a person do something they resist, or the restriction of liberty of movement whether or not the person resists.

To restrain a person under the MCA, the following criteria must be met:

1. The person lacks mental capacity in relation to the specific act.
2. It will be in the person's best interests for that act to be done.
3. It is reasonable to believe that it is necessary to restrain the person to prevent harm to themselves or to someone else.
4. The restraint is a proportionate response to the likelihood of the person suffering harm and the seriousness of that harm.

Examples of restraint include:

- locking a door to prevent a person who lacks capacity to leave a care home or ward,
- requiring that a person may only go out with another adult (escorted),
- physical restraint to enable staff to give required care,
- sedating a person to give medical care,
- using equipment to prevent a person moving freely,
- implementing bedrails without an appropriate risk assessment.

Each provider must follow their own organisation's policy and procedures about the prevention of, and application of, restraint or restriction. It is imperative that those applying restraint, in whatever form, must be qualified to do so and be up to date on the training in that respective technique.

An assessment of the person's mental capacity to consent to the use of physical intervention must be undertaken and documented. If the person does not have the capacity to consent best interests decision making must occur as stipulated by the MCA. The person should be told why the restraint is in place and that it is for their safety in a way they can understand.

If it is agreed that physical intervention may be required in the person's best interests this must be underpinned by a documented risk assessment which will inform their care plan (see own organisation's documentation). The risk

assessment should be reviewed regularly to determine if the restraint is still required.

The Deprivation of Liberty Safeguards (DoLS) are additional safeguards for people who lack mental capacity and are being deprived of their liberty, but do not receive mental health legislation safeguards. The DoLS Code of Practice provides a legal framework to protect those who may lack the capacity to consent to the arrangements for their treatment or care and where the level of restriction or restraint used in delivering that care are so extensive that they are depriving the person of their liberty and using Section 6 of the MCA is no longer sufficient.

Where a person does not have the capacity to consent, a multi-disciplinary meeting must be convened, and should include the family or carers of the person. The meeting should ensure best interests consultation and decision making occurs in line with MCA requirements, and this should be documented.

Supporting people to take positive risks can help increase their wellbeing as well as reducing reliance on restraint to maintain their safety. Talking openly about restraint with residents, patients, relatives and staff can help promote good practice. The following range of alternatives to restraint or restriction should be considered, and where feasible implemented, before moving to any form of restraint or restriction:

- Positive communication skills.
- Communication aids and translation services where needed.
- Provide prompts to aid the person's orientation of their environment.
- Assess the impact of environment on the person.
- Negotiation and persuasion skills.
- Draw on information in relevant documentation on the person's preferences, likes, dislikes etc.
- De-escalation and conflict resolution skills.

Any planned physical intervention must be relevant, reasonable, proportionate, and justifiable in the circumstances, utilise the minimum amount of force necessary for the shortest period of time and be in the person's best interests.

Consideration must always be given to the health and safety of the person. During the application of any physical intervention, continuous risk assessment of the person's physical and mental wellbeing should take place. Staff members must be aware of the risks associated with positional asphyxiation and consideration of abandoning the technique may be required in some situations.

Unplanned restraint

On occasion, restraint may be needed in an emergency. The person should be given a full explanation into the reason for the restraint and offered support as soon as possible after the incident.

A detailed record of the situation and actions taken before, during and after the incident should be made. This should be fully reviewed with the person, their family, staff and relevant professionals following any incident to determine if a risk assessment should be reviewed or put in place.

Covert medication

Each provider must follow their own organisation's policy and procedures around the covert administration of medication. Covert medication should only be used in exceptional circumstances and only when it is judged to be necessary and in line with the MCA since it is a serious interference with a person's autonomy and right to self-determination.

The covert administration of medication is only likely to be necessary or appropriate in the case of a person who actively refuses their medication and is judged not to have capacity to understand the consequences of their refusal.

A capacity assessment should be undertaken by the prescriber of the medication based on the concern that the person lacks the mental capacity to understand the need for the medication. There should also be a discussion with those involved in the person's care and interests including the LPA (for health and welfare). This should also include discussion with the staff who will be administering the medication and the family or representative, where possible. The guidelines published by NICE (National Institute for Health and Care Excellence) 'Medicines management in care homes' outline that medication should not be administered covertly until after a best interests meeting has been held, unless in urgent circumstances. Care homes must ensure that if a decision is taken to covertly administer medication, then a management plan should also be agreed and recorded after the best interests meeting.

The NICE guidelines can be accessed at:
www.nice.org.uk/guidance/qs85/chapter/quality-statement-6-covert-medicines-administration

In summary, where a best interests decision is to administer medication covertly, the rationale for this decision and the date for its review must be documented. Practitioners must follow their organisation's policy in relation to documentation of decisions to covertly administer medication.

All staff prescribing, administering or advising on covert medication should be aware of, and take into consideration, the requirements of the MCA.

Chapter 4: Consent and capacity

Consent and capacity are closely linked. Consent enables interventions to lawfully take place on the basis that people are adequately informed, have the capacity to consent, and are free from coercion. For consent to be valid, it must be given voluntarily by an appropriately informed person who has the capacity to consent to the intervention in question.

Acquiescence by the person to an intervention when they do not know or understand what this entails, is not consent. Where there is any doubt about the person's mental capacity to consent, the professional concerned should assess the capacity of the person to make the decision in question.

The seeking or giving of consent is a process rather than a one-off event. The validity of consent does not depend on the form in which it is given.

No-one is able to give consent to the examination or treatment of a person unable to give consent for him or herself. Therefore, relatives or members of the healthcare team cannot consent on behalf of such a person, although they can contribute to the decision making process.

Coercion and mental capacity

The MCA is expressly limited to people who lack capacity. There are no provisions in the MCA for individuals who may be unable to make a decision (or have difficulty making decisions) for a reason other than an impairment or disturbance in the functioning of the mind or brain. This includes people who are unable to make a decision free from duress or undue influence as a result of coercion and control. Such cases need to be looked at through the prism of safeguarding. If court action is needed it is likely to fall within the inherent jurisdiction of the High Court.

Capacity, consent and next of kin

The term next of kin (NoK) is commonly used and there is a presumption that the person that an individual identifies as their NoK has certain rights and duties. However, there is no legal basis for NoK.

There is only one situation where a NoK is legally valid; this is if a person dies without leaving a will. In this case, their estate will pass to the person or people who are their closest blood relation, also termed as their NoK.

A person identified as NoK should not be asked to sign and / or consent to interventions (unless they have a legal basis for doing so). An incorrect assumption is often made in hospitals, nursing or residential accommodation

where family members are asked to sign care plans, end of life plans and other treatment options, and provide ‘consent’ which is then not legally valid.

Note: A lasting power of attorney (LPA) is a legal document that lets a person appoint one or more people (known as 'attorneys') to help them make decisions or to make decisions on their behalf. This can include decisions about healthcare and personal welfare decisions where valid and applicable. See further information on the role of the LPA in **Chapter 9.**

Unwise decisions

The MCA states that “A person is not to be treated as unable to make a decision merely because he makes an unwise decision.”

Everybody has their own values, beliefs, preferences and attitudes, and practitioners should be mindful not to apply their own value judgements about what may be wise or unwise in respect of the decision to be made.

If a person is found to have mental capacity but it is considered that they are making an unwise decision or are proposing to take action(s) that may pose a risk to their health and well-being, consideration should be given as to how best to support them to minimise these risks.

Chapter 5: Safeguarding

Safeguarding adults

Safeguarding concerns may arise at any time during the course of an individual's involvement with an adult in need of care and support and / or their carer(s). Individuals and organisations must refer to the Sussex Safeguarding Adults Policy and Procedures.

Safeguarding concerns relating to an adult

Where there is a safeguarding concern, no action should be taken for, or on behalf of, any adult without first obtaining their consent. Wherever possible, every effort should be made to seek an adult's views and agreement regarding any action, unless doing so is likely to increase the risk to the adult or put others at risk.

All interventions must take into account the mental capacity of the adult to make informed choices, and specifically the adult's ability:

- To understand the implications of their situation and to take action themselves (or with support) to prevent abuse.
- To participate to the fullest extent possible in decision making about safeguarding interventions.

Where an adult has mental capacity and withholds consent in relation to a safeguarding enquiry or the sharing of information relating to a safeguarding concern, then practitioners should consider the following which may result in the overriding of the adult's wishes:

- If the adult is at significant risk of serious harm.
- If there is risk to others.
- If a criminal offence has taken place.
- Where action is needed in the public interest, such as where a member of staff is in a position of trust.
- If the adult is subject to undue influence or coercion and control.

Where an adult lacks capacity the principles of the MCA apply to the undertaking of a safeguarding enquiry.

Safeguarding concerns relating to others

Safeguarding concerns relating to others, i.e. other adults and / or carers may become apparent during the process of undertaking a mental capacity assessment and / or best interests decision-making. In such circumstances, individuals must refer to the Sussex Safeguarding Adults Policy and Procedures, and take the necessary action.

In addition, individuals should consider the potential impact upon others arising from a person lacking mental capacity to make a decision or where a person has capacity but is considered to be making an unwise decision. In such circumstances, an appropriate referral should be considered either under the Sussex Safeguarding Adults Policy and Procedures or the Care Act 2014.

Criminal offences

Section 44 of the MCA created the criminal offences of ill-treatment and wilful neglect, and these offences can be committed by anyone responsible for an adult's care and support needs. This includes:

- paid staff,
- family carers, and
- people who have the legal authority to act on the person's behalf (e.g. Power of Attorney or Deputy).

If any concerns are identified regarding the neglect, abuse or exploitation of an adult with care and support needs, consideration should be given to raising a safeguarding concern with Adult Social Care & Health and / or notifying the police.

Chapter 6: Interface with Mental Health Act 1983 (amended 2007)

The Mental Capacity Act 2005 (MCA) does not apply to treatment for a mental disorder where a person has been detained under the Mental Health Act 1983 (MHA), as the MHA allows treatment to be given without a person's consent (section 28, MCA).

The MHA applies to people of all ages; the MCA applies to anyone over the age of 16 years.

A Lasting Power of Attorney (LPA) and a Court of Protection appointed deputy cannot consent to, or refuse, treatment for mental disorder (on a patient's behalf). Also an advance decision to refuse treatment (ADRT) which refuses medical treatment for a mental disorder can be overridden where necessary. The exception to this is electroconvulsive therapy (ECT) when a refusal of ECT in a valid and applicable ADRT or expressed by an LPA or a deputy will be legally binding on healthcare professionals.

A valid and applicable ADRT, or decision by an LPA, for any illness or condition other than mental disorder will be legally binding on healthcare professionals. Also, where a detained person lacks capacity to consent to treatment, other than for mental disorder, the decision maker will need to act in accordance with the MCA. If time allows, it may be possible to treat a mental disorder under the MHA in order to allow the person to regain capacity to make a decision about treatment for a physical disorder (see MCA Code of Practice 13.26 – 13.37).

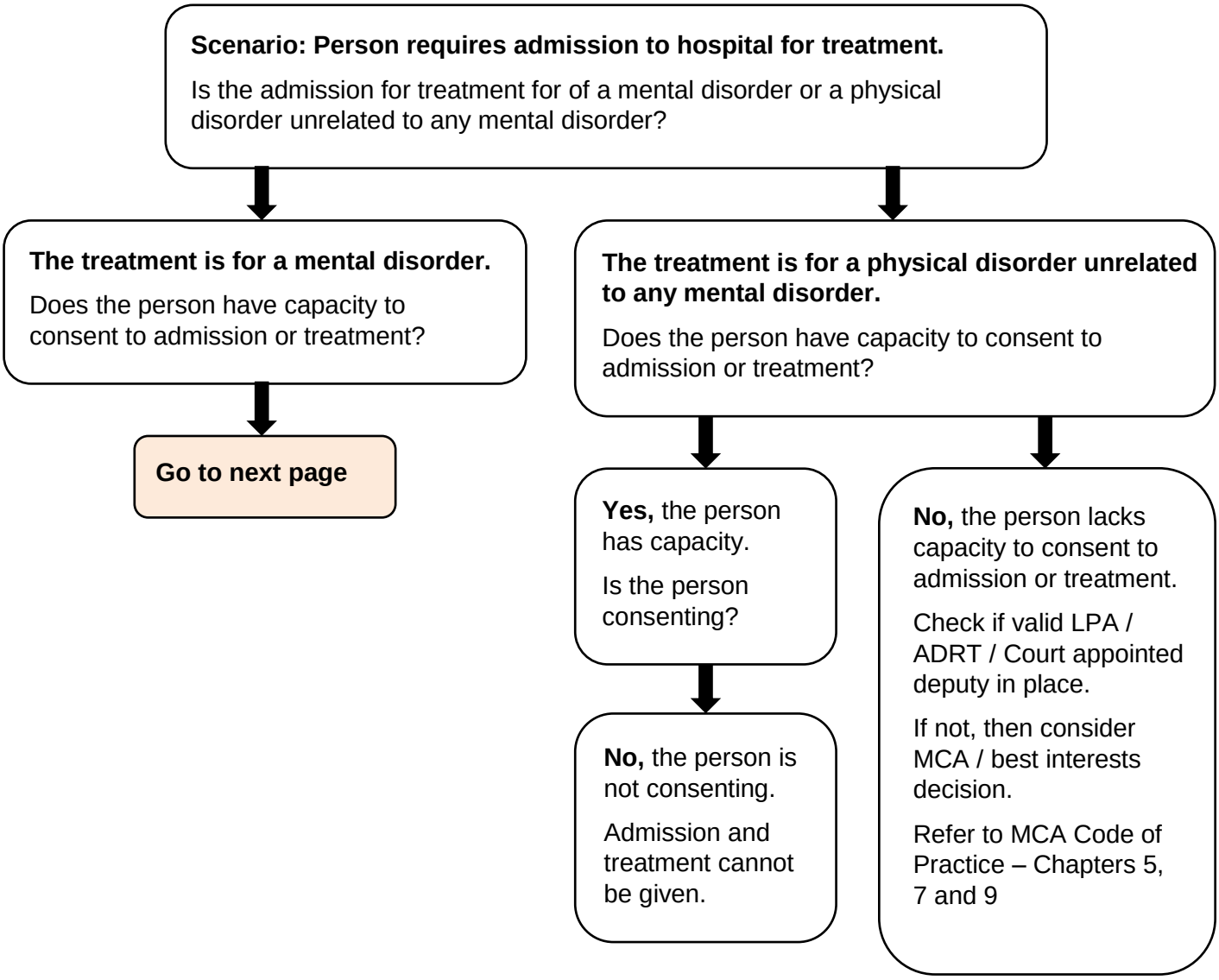
Although informal admission should be the preferred mode of admission, there is nothing in the MHA which expressly prevents an application being made in respect of a mentally capable person who is willing to enter hospital as an informal patient. Compulsion should be considered for adults whose history suggests that they might have a change of mind about being admitted informally.

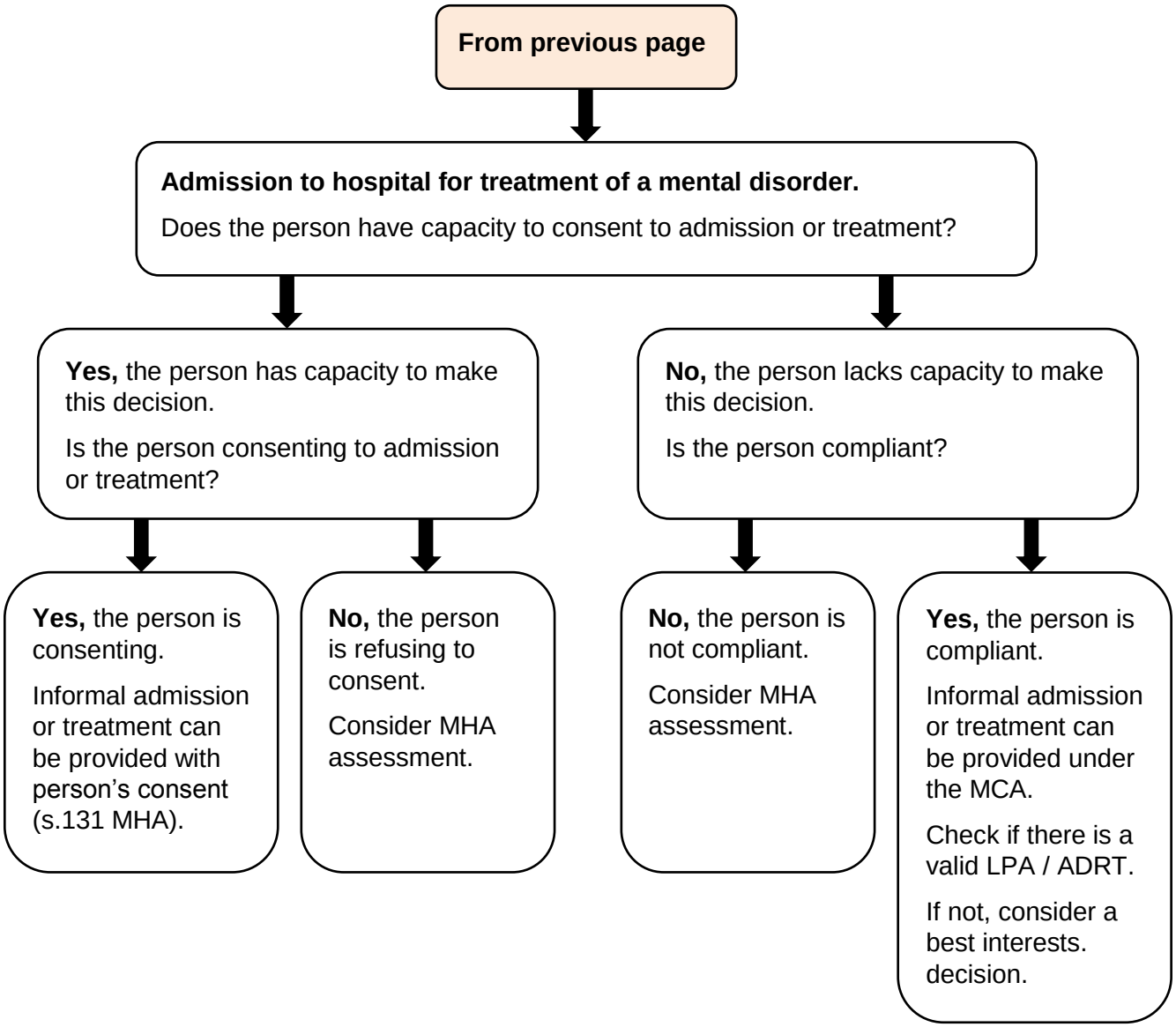
There may be instances when an adult is subject to both the MHA and MCA. For example, an adult may be detained under the MHA for treatment of their mental disorder, and require treatment for a physical disorder. The adult may be subject to the MHA and transferred to a medical hospital / ward for physical treatment and once there a mental capacity assessment must be completed to determine if the treatment is needed.

If the person is subject to the MHA as well as the MCA a family member who may describe themselves as the person's 'next of kin' may be different to the Nearest Relative under MHA as defined in Section 26 MHA 1983/2007.

See additional information on next of kin in **Chapter 4 'Capacity, consent and next of kin.'**

MHA or MCA?


Scenario: Person requires admission to hospital for treatment.
Is the admission for treatment for of a mental disorder or a physical disorder unrelated to any mental disorder?
The treatment is for a mental disorder.
Does the person have capacity to consent to admission or treatment?
Go to next page
The treatment is for a physical disorder unrelated to any mental disorder.
Does the person have capacity to consent to admission or treatment?
Yes, the person has capacity.
Is the person consenting?
No, the person is not consenting.
Admission and treatment cannot be given.
No, the person lacks capacity to consent to admission or treatment.
Check if valid LPA / ADRT / Court appointed deputy in place.
If not, then consider MCA / best interests decision.
Refer to MCA Code of Practice – Chapters 5, 7 and 9


From previous page
Admission to hospital for treatment of a mental disorder.
Does the person have capacity to consent to admission or treatment?
Yes, the person has capacity to make this decision.
Is the person consenting to admission or treatment?
No, the person lacks capacity to make this decision.
Is the person compliant?
Yes, the person is consenting.
Informal admission or treatment can be provided with person's consent (s.131 MHA).
No, the person is refusing to consent.
Consider MHA assessment.
No, the person is not compliant.
Consider MHA assessment.
Yes, the person is compliant.
Informal admission or treatment can be provided under the MCA.
Check if there is a valid LPA / ADRT.
If not, consider a best interests. decision.

General points to remember

- Assessment of a person's capacity to consent is an ongoing exercise and should be repeated regularly.

- If capacity is fluctuating in relation to treatment for a mental disorder then consider application of the MHA.

- The informal admission to hospital and subsequent medical treatment of any compliant mentally incapacitated person can be provided under the MCA, if the person is not being deprived of their liberty in hospital. Where it is considered the person is likely to be deprived of their liberty, then consideration should be given to an MHA assessment (to enable treatment of a mental disorder) or a DoLS referral (to authorise continued hospital admission).

- For those aged under 16 years – if a child is considered to lack ('Gillick') competency to consent to admission and / or treatment and it is considered that the admission or treatment would amount to a deprivation of liberty, then a decision under the MHA is required (if the criteria are met). If the criteria are not met, the child cannot be admitted or treated without court authorisation, although action can be taken in life-threatening emergencies.

- A valid and applicable advance decision to refuse treatment (ADRT) for mental disorder (medication only) can be overridden by detaining the patient under the MHA. This does not apply to ECT treatment.

Please also refer to your local MHA and MCA policies.

Chapter 7: Children and young people

Within the MCA, 'children' refers to people below the age of 16 while 'young people' refers to people aged 16 – 17. This differs from the Children Act 1989 and the law more generally; where the term 'child' is used to refer to people aged under 18.

The MCA does not generally apply to people under the age of 16 with the exception of:

- offences of ill-treatment or wilful neglect, and
- the Court of Protection's power to make decisions about a child's property or finances where the child lacks capacity to make such decisions and is likely to still lack capacity to make such financial decisions when they reach the age of 18.

Ill-treatment and wilful neglect only applies if the child's lack of capacity to make a decision for themselves is caused by an impairment or disturbance that affects how their mind or brain works, and is not due to the child's youth or immaturity when it would be dealt with under the separate offences of child cruelty or neglect.

Care and treatment of children under the age of 16 is generally governed by common law principles.

Most of the MCA applies to young people aged 16 – 17 years. There are four exceptions:

- Only people aged 18 and over can make a Lasting Power of Attorney.
- Only people aged 18 and over can make an advance decision to refuse medical treatment (ADRT).
- The Court of Protection may only make a statutory will for a person aged 18 and over.
- Deprivation of Liberty Safeguards (DoLS) can only be utilised for people who are 18 and over.

Issues relating to children and young people must be judged on their own set of circumstances and referral to legal services, where appropriate.

Chapter 8: Information sharing

Sometimes third parties may request information about someone who has been assessed as lacking capacity. Chapter 16 of the MCA Code of Practice offers guidance relating to the rules which govern access to information.

The following is a summary of key principles relating to information sharing:

- Consider whether the person who has been assessed as lacking capacity in relation to a specific decision may nevertheless have the capacity to consent to the information being disclosed. If so, the person's consent should be sought.

- Consider whether the person making the request for confidential information has lawful authority to ask for it e.g. the person is a validly appointed attorney

- Practitioners must be satisfied that the person making the request for information is acting in the best interests of the adult who lacks capacity, and needs the information to act properly.

- If a decision is made to share information, practitioners should ask the recipient to confirm that they will keep that information safe, confidential and for no longer than is reasonably necessary for the purpose requested.

- If a decision is reached (based upon the needs and best interests of the adult lacking capacity) not to share the information with the adult's carer, the MCA Code of Practice encourages practitioners to try to resolve the matter initially through discussion with the carer.

- Practitioners should ensure that they record all instances of information sharing and their justification for sharing at that point in time.

More specific advice can be obtained from the Information Commissioner's Office at https://ico.org.uk/.

Chapter 9: Legislation – other remedies

The Court of Protection

The Court of Protection has jurisdiction relating to the MCA and is the final arbitrator for matters relating to mental capacity. The Court can make declarations, decisions or orders on financial and welfare matters affecting people who lack capacity to make those decisions. The Court can determine, amongst other things, a person's place of residence (where that is in dispute), contact with family and friends, prevent individuals from acting in certain ways towards the person concerned issues relating to serious medical treatment. The Court can also resolve disputes in relation to a person's capacity.

The Court of Protection has powers to:

- Decide whether a person has capacity to make a particular decision for themselves.
- Appoint deputies to make decisions for people lacking capacity to make those decisions.
- Decide whether a Lasting Power of Attorney (LPA) or Enduring Power of Attorney (EPA) is valid.
- Remove deputies or attorneys who fail to carry out their duties.

Inherent jurisdiction

Inherent jurisdiction is a doctrine of English common law whereby a superior court has the jurisdiction to hear any matter that comes before it, unless a statute or rule limits that authority or grants exclusive jurisdiction to another court or tribunal.

The regulations of the MCA have replaced the inherent jurisdiction of the High Court in the case of mentally incapacitated people. However, the High Court still uses inherent jurisdiction for cases in which vulnerable adults possess mental capacity but require protection for certain reasons. The aim of the High Court in these cases is (most often) pre-emptive intervention; to prevent circumstances in which an adult might not be able to exercise free choice at some point in the future, for example, due to coercion or undue influence.

The Office of the Public Guardian (OPG)

The OPG was established by the MCA. It has a responsibility to support people and help them plan ahead so that their health, welfare and financial decisions will

be taken care of if they lose mental capacity, and to safeguard the interests of people who may lack capacity to make certain decisions themselves.

The OPG is responsible for maintaining a register of EPAs, LPAs and court orders appointing deputies. It also has a legal duty to supervise deputies appointed by the Court of Protection, and to investigate concerns or complaints about the actions of deputies, registered attorneys and people acting under an order of the Court of Protection.

Further information can be found at:

https://www.gov.uk/government/organisations/office-of-the-public-guardian

Lasting Powers of Attorney (LPA) / Enduring Powers of Attorney (EPA)

The LPA was introduced by the MCA. This replaces the former EPA, which after 1 October 2007 can no longer be created. However, a person given a power under an EPA before this date can still use it and apply to have it registered. An LPA is a legal document that allows a person (the Donor) to appoint someone they trust (the Attorney) to make decisions on their behalf.

There are two types of LPA:

- Finance and Property – decisions relating to finances, including the management of the Donor's property and affairs.
- Health and Welfare – decisions relating to the Donor's health and welfare, including decisions to refuse or consent to treatment, and deciding where to live.

The LPA must be registered with the OPG in order to have legal standing. A registered LPA can be used at any time, whether the person making the LPA has mental capacity to act for him / herself or not. Once the LPA is registered it continues indefinitely. The LPA can be registered by the Attorney after the Donor has lost capacity. An LPA can also be cancelled by the Donor provided he / she has capacity to do so.

Advance decisions to refuse treatment

An advance decision to refuse treatment (ADRT) enables someone aged 18 or over, whilst still capable, to refuse specified medical treatment for a time in the future when they may lack capacity to consent to or refuse that treatment.

ADRTs will not be applicable:

- if the person has the capacity to make the decision when the treatment(s) concerned is / are proposed, or
- in circumstances not specified in the decision, or
- where there are reasonable grounds for believing that the current circumstances were not anticipated by the person.

If an ADRT relates to life-sustaining treatment it must be made in writing, signed and witnessed, and state clearly that the decision is valid even if life is at risk. In all other circumstances, there is no requirement for an ADRT to be made in writing. However, encouragement should always be given to any individual to put their wishes in writing and to inform those closest to them of the existence of such a document.

An ADRT cannot be used to request or demand treatment.

Note An ADRT may not apply where the person is, or is liable to be, detained under the Mental Health Act 1983 (amended 2007).

Advance statements

An advance statement is a written statement that sets down preferences, wishes, beliefs and values regarding future care. The aim is to provide a guide to anyone who might have to make best interests decisions on behalf of the person if they lose mental capacity in the future. An advance statement can cover any aspect of future health or social care.

An advance statement is not legally binding, but it must be taken into account by a decision maker when a best interests decision is being considered. An advance statement does not need to be signed and witnessed.

Deprivation of liberty

The term deprivation of liberty can apply in a range of different circumstances, as the Deprivation of Liberty Safeguards under the MCA, deprivation of liberty for adults over the age of 18 years in community settings and in relation to children under the age of 16 years and young people aged 16/17 years.

Deprivation of Liberty Safeguards (DoLS)

DoLS were introduced into the MCA in 2007. These safeguards focus on providing protection to those vulnerable adults who for their own safety and in their own interests need to be accommodated under care and treatment regimens that may

have the effect of depriving them of their liberty, but who lack the capacity to consent. Depriving a person of their liberty is a very serious matter and should not happen unless it is absolutely necessary and in the best interests of the person concerned.

The DoLS apply to anyone:

- aged 18 and over,
- who is deemed to lack the mental capacity to make a specific decision,
- who suffers from a mental disorder or disability of the mind, such as dementia or a profound learning disability, but may include some people who have, for example, suffered a brain injury,
- who lacks the capacity to give informed consent for their care and support and / treatment that they require and the arrangements for this, and
- for whom deprivation of liberty (within the meaning of Article 5 of the European Convention on Human Rights) is considered after an independent assessment to be necessary in their best interests to protect them from harm.

The DoLS can only be used if the person will be deprived of their liberty in a care home or hospital. In other settings, the Court of Protection can authorise a deprivation of liberty.

The safeguards do not apply to people detained under the Mental Health Act 1983 (amended 2007).

The safeguards provide for deprivation of liberty to be made lawful through 'standard' or urgent authorisation processes, and are designed to:

- provide safeguards and ensure people can be given the care they need in a less restrictive manner,
- prevent arbitrary decisions that deprive vulnerable people of their liberty,
- provide people with the right of challenge against unlawful detention.

The DoLS mean that a hospital or care home must seek authorisation from a 'supervisory body' (the local authority), in order to be able to deprive someone of their liberty lawfully. Before giving such authorisation, the supervisory body must be satisfied that the person has a mental disorder as defined in section 1 of the Mental Health Act 1983 (as amended by the Mental Capacity Act 2005) and lacks capacity to decide about their residence or treatment.

A decision whether or not a deprivation of liberty arises will depend on all the circumstances of the case. It is neither necessary nor appropriate to apply for a

deprivation of liberty authorisation for everyone who is in hospital or a care home simply because the person concerned lacks capacity to decide whether or not they should be there. In deciding whether or not an application is necessary, the hospital or care home (the managing authority) should consider carefully whether any restrictions that are, or will be, needed to provide on-going care or treatment amount to a deprivation of liberty when looked at together.

Deprivation of liberty in community settings

In March 2014, the Supreme Court handed down its judgment in the case of 'P v Cheshire West and Chester Council and another' and 'P and Q v Surrey County Council' which clarified whether arrangements made for the care and / or treatment of an individual lacking capacity to consent to those arrangements amount to a deprivation of liberty for the purpose of Article 5 of the European Convention on Human Rights.

The judgement set out the 'acid test' for determining a deprivation of liberty:

- that the person is under continuous supervision and control, and
- is not free to leave.

The Supreme Court held that a deprivation of liberty can occur in domestic settings, as well as in care homes and hospitals, where the state is responsible for imposing such arrangements. This will include a placement in a supported living arrangement or even in someone's own home in the community. Such placements, or where there is likely to be such a placement, must be authorised by the Court of Protection.

Deprivation of liberty in children and young people

Each case should be judged on its own merit and legal advice sought in all cases.

Care Act 2014

There is a statutory obligation under the Care Act 2014 to promote individual wellbeing, and this begins with the assumption that the person is best placed to judge their situation.

It places a duty on the local authority to ensure that:

- The person participates as fully as possible in decisions, and is given the information and support necessary to enable them to participate.

- Decisions are made having regard to all the individual's circumstances (and are not based on the person's age or appearance or other condition or behaviour).

- Any restriction on the individual's rights or freedom of action is kept to the minimum necessary for achieving the purpose.

The principles that underpin the MCA mirror these duties.

Appendices

Appendix 1: Mental Capacity Act 2005 Code of Practice

The legal framework provided by the Mental Capacity Act 2005 is supported by this Code of Practice, which provides guidance and information about how the Act works in practice. The Code of Practice has a statutory force, which means that certain categories of people have a legal duty to have regard to it when working with or caring for adults who may lack capacity to make decisions for themselves.

The Mental Capacity Act Code of Practice can be found at:

https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice

Appendix 2: Exceptions – decisions which cannot be made under the MCA 2005

No one (including the Court of Protection) can make a decision on another's behalf about:

- Consenting to marriage or a civil partnership.
- Consenting to have sexual relations.
- Consenting to a decree of divorce being granted on the basis of two years' separation.
- Consenting to a dissolution order being made in relation to a civil partnership on the basis of two years' separation.
- Consenting to a child being placed for adoption by an adoption agency.
- Consenting to the making of an adoption order.
- Discharging parental responsibilities in matters not relating to a child's property.
- Giving consent under the Human Fertilisation and Embryology Act 1990 (c.37).
- Voting at an election for any public office or at a referendum.

Although the MCA does not allow anyone to make a decision about these matters on behalf of anyone who lacks capacity to make such a decision for themselves, this does not prevent action being taken to protect an adult from abuse, neglect or exploitation.

The Court of Protection will make decisions where the person lacks capacity on the points above and also in other decisions.

Treatment under Part IV of the Mental Health Act 1983

Medical treatment for a mental disorder of a person who is subject to Part IV of the Mental Health Act 1983 is not covered by the Mental Capacity Act 2005. Further guidance is given in Chapter 13 of the MCA Code of Practice.

Research

There are extra rules relating to carrying out research with people who lack capacity to consent to the research. For further information, please see Chapter 11 of the Code of Practice.

Appendix 3: Deprivation of Liberty Safeguards (DoLS) Code of Practice

The Deprivation of Liberty Safeguards (DoLS) Code of Practice helps explain how to identify when a person is, or is at risk of, being deprived of their liberty and how a deprivation of liberty may be avoided. It also explains the safeguards that have been put in place to ensure that deprivation of liberty, where it does occur, has a lawful basis.

The DoLS Code of Practice can be found at:

http://webarchive.nationalarchives.gov.uk/20110322122009/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085476

Appendix 4: Decision-making and mental capacity: NICE guideline

This guideline for health and social care practitioners covers decision making in people 16 years and over who may lack capacity now or in the future.

The guideline can be found at:

https://www.nice.org.uk/guidance/ng108/resources/decisionmaking-and-mental-capacity-pdf-66141544670917

Appendix 5: East Sussex Safeguarding Adults Board Resolution Protocol

This protocol sets out a resolution process for disagreements between agencies or professionals in relation to safeguarding or mental capacity decision making, highlighting the importance of effective partnership working and professional co-operation in resolving any disagreements in the shortest timescales possible.

The SAB resolution protocol can be found at:

https://www.eastsussexsab.org.uk/wp-content/uploads/2019/01/East-Sussex-SAB-Resolution-Protocol-2019.pdf

Appendix 6: National Mental Capacity Act Competency Framework

The National Mental Capacity Act Competency Framework has been produced by Bournemouth University in association with the National Mental Capacity Forum and a number of key national organisations working in the area of mental capacity.

The National Mental Capacity Act Competency Framework can be found at:

http://www.ncpqsw.com/financial-scamming-publications/national-mental-capacity-act-competency-framework/

Appendix 7: Next of Kin: Understanding decision making authorities

This leaflet has been produced by Bournemouth University. It clarifies the roles and responsibilities of a Next of Kin and how people can plan ways to ensure their wishes are taken into account if, in the future, they cannot make decisions for themselves.

The leaflet can be found at: http://www.ncpqsw.com/financial-scamming-publications/nok/

Appendix 8: Dementia Decisions: Are you making decisions on behalf of someone you're looking after?

This guide to the Mental Capacity Act has been produced for carers, and is designed to provide advice for those who are caring for people who may need help to make decisions, or may need another person to make decisions on their behalf.

The Dementia Decisions guide can be found at:

https://www.scie.org.uk/files/mca/directory/guide-to-the-mental-capacity-act-for-people-caring-for-someone-with-dementia-sitra-2016.pdf?res=true

Appendix 9: The interface between the Mental Health Act 1983 (MHA) and the Mental Capacity Act 2005 (MCA)

The following table provides guidance on several key factors to consider when deciding on whether to use the MHA or MCA. Use of this table should not be relied upon as an alternative to legal advice.

	Yes	No
Is the person under 16?	Only the MHA can be used.	Either the MHA or MCA can be used.
Does the person have a mental disorder?	Either the MHA or the MCA can be used.	The MCA can be used if the person has an 'impairment of or disturbance in the functioning of the mind or brain'.
Is the proposed treatment for mental disorder?	Either the MHA or the MCA can be used.	If the person lacks capacity, only the MCA can be used.
Do they have capacity to consent to treatment?	Only the MHA can be used to treat them if they refuse treatment for their mental illness.	Either the MHA or the MCA can be used. **Note** If the person's capacity will be regained in the near future, the MCA will be of limited use.
Do they meet the criteria for detention under the MHA?	If they meet the criteria for detention under the MHA and are in a unit registered to use the Act then the MHA must be used. However, if the person is not in a place registered to use the MHA, the use of DoLS may apply.	Only the MCA can be used. **Note** This could include DoLS under the MCA.
Do they have an advance decision to refuse treatment (ADRT) for mental disorder?	To override an ADRT, the MHA would have to be used. **Note** Special rules apply to electro-convulsive therapy.	Either the MHA or the MCA can be used.

	Yes	No
Does their Lasting Power of Attorney or Deputy or Court of Protection ruling refuse treatment for mental disorder?	To override this refusal, the MHA would have to be used. **Note** Special rules apply to electro-convulsive therapy.	Either the MHA or the MCA can be used.
Is restraint needed or in use? **Note The MHA fails to define restraint but the MCA does.**	MHA Code of Practice (para 15.34) 'If a patient is not detained, but restraint in any form has been deemed necessary, consideration should be given to whether formal detention under the Act is appropriate (subject to the criteria being met)'. If there is evidence of the person objecting to care, the MHA has primacy (other criteria being met).	Either the MHA or the MCA can be used.
Is their capacity fluctuating, or could improve quickly, and they would then refuse care or treatment?	Use the MHA in preference as the MCA would be of limited use.	Either the MHA or the MCA can be used.
Could the MCA be used as a less restrictive option?	Use the MCA as a starting point.	Use the MHA.