

Mental Capacity Act Policy

Version number :	1.2
Consultation Groups	Mental Health Law Monitoring Group
Approved by (Sponsor Group)	Mental Health Law Monitoring Group
Ratified by:	Quality Committee
Date ratified:	28 th July 2021
Name of originator/author:	Guy Davis – Associate Director in Mental Health Law
Executive Director lead :	Paul Guilluley
Implementation Date :	June 2021
Last Review Date	June 2021
Next Review date:	June 2024

Services	Applicable
Trustwide	Yes
Mental Health and LD	
Community Health Services	

Version Control Summary

Version	Date	Author	Status	Comment
2.0	20 th January 2016	Johanna Turner	Final	Creation of document covering the legislation pertaining to mental capacity
2.1	8 January 2018	Johanna Turner		Guidance on completion of documentation for staff who do not use RiO
2.2	15 June 2021	Johanna Turner		Minor grammatical changes

Contents

Paragraph		Page
i.	Executive Summary	4
1.0	Definitions	5
1.2	Introduction	6
2.0	Key Principles	6
3.0	Assessment of Capacity	7-10
	<ul style="list-style-type: none"> • Best interests • Protection from liability • Restraint • Advance decisions to refuse treatment • Criminal offences • Decision making by others • Interface between Mental Health Act 1983 & Mental Capacity Act 2005 	10 11 11 11-12 12 12-13 13-14
4.0	Roles and responsibilities under the Act	14-16
	Appendix 1 - Mental Health Law Contacts	17
	Appendix 2 - MHA/DoLS Flowchart	18

Executive Summary

- The policy sets out the law and associated guidance in respect of mental capacity and deprivation of liberty in general.
- The main legislative mechanism is the Mental Capacity Act 2005. Although this Act of Parliament could apply to those under the age of 18 years, the Children Act 1989 and the Family Law Reform Act 1969 are also key pieces of legislation when it comes to the treatment of children and young people.
- The policy covers each legal perspective in situations involving adults and children, but each case will have its own unique characteristics.
- This policy should be read in conjunction with the policies on Community Treatment Orders, Electro Convulsive Therapy, Consent to Treatment Policy, Advance Decisions to Refuse Medical Treatment, Deprivation of Liberty Policy, Safeguarding Vulnerable Adults, Covert Administration of Medicines Policy and Care Programme Approach.

1.0 Definitions

- 1.1 **Mental Capacity Act 2005 (MCA)** – The Mental Capacity Act 2005 provides a statutory framework to empower and protect vulnerable people who are not able to make their own decisions. It makes clear who can take decisions in which situations and how they should go about this. It also enables people to plan ahead for a time when they lose mental capacity.
- 1.2 **Advance decision to refuse treatment** – a refusal of future treatment made by someone who has mental capacity to do so. It will be legally binding if deemed valid and applicable.
- 1.3 **Independent Mental Capacity Advocate (IMCA)** – an independent person instructed to support and represent a person who lacks capacity to make decisions normally if that person is unbefriended, in that they have no family, friends or carers to consult as to what would be in that persons best interest.
- 1.4 **Deprivation of Liberty (DoL)** – A term used to describe the circumstances in which a person’s freedom is severely limited to the extent that they are not allowed to leave their environment, they are under continuous supervision and control and they lack capacity to consent to this situation
- 1.5 **Consent** - Consent is the voluntary and continuing permission of a patient to be given a particular treatment, based on a sufficient knowledge of the purpose, nature, likely effects and risks of that treatment, including the likelihood of its success and any alternatives to it. Permission given under any unfair or undue pressure is not consent.¹ There is no statute in English Law which sets out the general principles of consent. However, case law has established that touching someone without their valid consent may constitute an offence of battery.² A person who lacks capacity to consent is unable to consent or refuse treatment, even if they co-operate with the treatment or actively seek it.³

¹ Department of Health 2015 *Code of Practice* The Stationary Office Para 24.34

² Department of Health 2009 *Reference Guide to consent for examination or treatment 2nd Ed.* Para 2 page 5
www.dh.gov.uk/consent

³ Department of Health 2015 *Code of Practice* The Stationary Office Para 24.35

Mental Capacity Act 2005

1.2 Introduction

The Mental Capacity Act 2005 came into force in October 2007 and regulates care and treatment for those people who lack capacity (where the Mental Health Act 1983 does not apply). It generally applies to people over the age of 18 but some parts apply to those people aged between 16 and 18.

The Mental Capacity Act 2005 essentially codified common law rights of autonomy and bodily integrity. It allows for others to make decisions on behalf of the person without capacity (lasting power of attorney, deputies appointed by the Court of Protection etc.) and allows for people to make decisions in advance as to which treatments they do not want in the event that they lose capacity ('advance decision to refuse medical treatment').

The Mental Capacity Act 2005 also provides protection for those carers/professionals caring for people who lack capacity provided the care that is carried out is in their best interest (section 5) and if restraint is used, then that restraint is a proportionate response to the likelihood and seriousness of harm which might occur if the person was not restrained (section 6).

2.0 Key Principles the Mental Capacity Act 2005

2.1 The Act is underpinned by a set of five key principle found in section 1. These principles should be considered whenever someone is planning to make a decision under the Act:

- A presumption of capacity – every adult has the right to make his or her own decisions and they must be assumed to have capacity to do so unless it is established otherwise.
- The right to be supported to make their own decisions – people must be given all appropriate and practicable assistance before anyone concludes they cannot make their own decisions.
- The individual must retain the right to make what may seem to others to be an eccentric or unwise decision.
- Best interests – anything done for or on behalf of people without capacity should be in their best interests; and
- Least restrictive intervention – anything done for or on behalf of a person without capacity should be the least restrictive of their basic rights or freedoms.

Purpose

2.2 This policy underpins the application of the Act in East London NHS foundation Trust and partner organisations. It sets out the main features of the Act, identifies the duties placed on health care staff and provides a procedure to determine the circumstances in which the processes described in the Act are initiated. This policy must be followed when any act in relation to care or treatment is carried out for persons who are required to make a decision or choice.

Scope

2.4 The Act applies to people of 16 or over who lack capacity to make their own decisions. Some provisions of the Act apply to adults over the age of 18 only and those circumstances, reference should be made to other legislation or case law to determine what action should be taken for those persons under the age of 18 who are deemed to be unable to make their own decisions.

3.0 Assessment of Capacity

3.1 Any assessment of mental capacity must be based on a person's ability to make a specific decision and the time it needs to be made. The person who assesses an individual's capacity to make a decision will usually be the person who is directly concerned with the individual at the time the decision in question needs to be made. In most cases, the assessment of capacity will be relatively straightforward and can be undertaken by any member of a clinical team with appropriate training. But in more complex cases it may be necessary to obtain an opinion from another professional, discuss within the multi-disciplinary team or seek advice from the Trusts Mental Health Law Office.

3.2 Assessments of capacity are a continuous and on-going process throughout an episode of care. It is not possible to list all eventualities when a capacity assessment should be carried out; however as a minimum, a capacity assessment must be completed in the following circumstances:

- Informal admission to hospital/ admission under detention
- When a detained patient becomes subject to compulsory powers under a community treatment order

- To comply with the requirements of section 58, 58A and part 4A of the Mental Health Act 1983
- Serious medical treatment
- When there is a significant change in mental state
- Significant change of accommodation
- A necessary breach of confidentiality
- Any situation where there is a consideration that the person may be being deprived or their liberty
- Other important decisions which may involve treatment, finances, personal affairs, property etc.

It is important that if there are any doubts as to when capacity should be assessed, this is discussed in the first instance by the multi-disciplinary team and if necessary, escalated to the relevant mental health law office. In line with the above, the professional carrying out the assessment should be the one identified as responsible for the decision in question but second or other's opinions may be sought. The ultimate decision however will remain with the professional responsible for that care or treatment/ other decision. Any professional who claims that an individual lacks capacity should be able to provide proof. They need to be able to show, *on the balance of probabilities*, that the individual lacks capacity to make a particular decision, at the time it needs to be made.

3.3 A person who lacks capacity is defined under s.2(1) MCA 2005 thus:

'a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or the brain.'

This is a two stage test, made up of a diagnostic and functional element. It should be noted that following a recent legal judgement, some organisations prefer to complete stage 2 prior to completing stage 1. In any event, an assessment of a lack of capacity must demonstrate the 'causative nexus' i.e. the direct link between the impairment/ disturbance and the inability to make the decision in question

- Stage 1

The diagnostic test requires proof that the person has an impairment of the mind or brain, or some sort of or disturbance that affects the way their mind or brain works. If a person does not have such an impairment or disturbance of the mind or brain, they will not lack

capacity under the Act. Examples of an impairment or disturbance in the functioning of the mind or brain may include the following:

- conditions associated with some forms of mental illness
 - dementia
 - significant learning disabilities
 - the long-term effects of brain damage
 - physical/medical conditions that cause confusion, drowsiness, loss of consciousness
 - delirium
 - concussion following a head injury, and
 - the symptoms of alcohol or drug use.
-
- Stage 2

For a person to lack capacity to make a decision, the Act says their impairment or disturbance must affect their ability to make the specific decision when they need to.

The functional test requires proof of an 'inability to make a decision'. A person is unable to make a decision if they cannot:

1. understand information about the decision to be made (the Act calls this 'relevant information'), or
2. retain that information in their mind, or
3. use or weigh that information as part of the decision-making process, or
4. communicate their decision (by talking, using sign language or any other means).

If it is reasonably believed, on the balance of probabilities, that the person is unable to do one or more of the above and this is because of the impairment or disturbance in their mind or brain then they will be deemed to be lacking capacity in relation to the particular decision in question. Any assessment of capacity should be contemporaneously recorded in the patient's electronic records specifically on the appropriate template where accessible in the bespoke mental capacity folder and an entry made in the progress notes regarding completion. Other electronic systems within the Trust may not have a relevant capacity template for use and in these circumstances either a paper form should be completed and uploaded or the assessment should be fully recorded within the progress notes. As well as the outcome of the test, the following should be recorded:

- the specific decision for which capacity was assessed
- the salient points that the individual needed to understand and what information was presented to the person
- steps taken to promote the individual's ability to decide themselves

- how the diagnostic test (see above) was assessed and how the assessor came to their conclusion
- how the functional test (see above) was undertaken and how the assessor reached their conclusion⁴

This should be followed where appropriate by the formulation of an appropriate care plan. Professionals must seek to involve those who lack capacity in decisions about their care as much as they would those who have capacity. Care plans must determine what is in a person's best interests (see below) and reflects consideration of the persons wishes, feelings, beliefs and values and, where appropriate, is developed in consultation with others such as carers, about what is in the persons best interests.⁵

Best Interests

3.4 Once a lack of capacity in relation to a particular decision has been established, any further decision then made on the person's behalf must be in their best interest as per the MCA principle above. In determining what is in a person's best interest, regard must be had (by the person making the decision on behalf of the incapacitated person) to all relevant factors that it would be reasonable to consider, not just those that they think are important. They must not act or make a decision based on what they would want to do if they were the person who lacked capacity. Section 4 of the MCA provides a check list of what should be considered when determining a person's best interest including:

- whether the person is likely at some point in the future to regain capacity (in which case can the decision be deferred until that point?)
- whether there are any additional means that can be employed to enable the person to participate or be involved more fully in the decision making
- the ascertainable past and present wishes and feelings of the person and their beliefs, values and other factors that may influence them if they had capacity
- the views of relatives, carers, or others who it would be practicable and appropriate to consult about the persons wishes and feelings.

For everyday acts of care and treatment, there is no requirement to formally set out how a best interest decision has been made, the care and treatment in question should form part of the current care plan as described above. However with more complex decisions such as those concerning medical treatment or a move to long term alternative accommodation,

⁴ Department of Health 2015 *Code of Practice* The Stationary Office Para 13.22

⁵ Department of Health 2015 *Code of Practice* The Stationary Office Para 13.25

best interest decisions must be formally documented, either using the bespoke electronic template where available and with a further entry made in the progress notes or in the progress notes or via an uploaded form for other electronic systems.

Protection from Liability in connection with acts associated with care and treatment

3.5 Where care or treatment is provided for someone who lacks capacity, this can be delivered without the carer incurring any legal liability by meeting the conditions of section 5 of the Mental Capacity Act. This means that as long as any act of care and treatment is carried out in the person's best interest (see 3.4 above) following an assessment and confirmation that the person lacks capacity, there will be protection from liability. This includes acts that would otherwise be classified as a civil wrong or a crime if it concerned interfering with a person's body or property in the ordinary course of carrying out the act in question.

Restraint

3.6 The Act defines restraint at section 6 as any restriction of liberty of movement (whether or not the person resists) or the use or threat of use of force where an incapacitated person is resisting. Restraint is only permitted if the person using it reasonably believes that the restraint is necessary to prevent harm from befalling the person and the restraint is proportionate to the likelihood and seriousness of the harm occurring if the person was not restrained. This does not include the right to deprive a person of their liberty without also following legal safeguards (see below).

Advance decision to Refuse Treatment

3.7 The Act allows for people to make a decision in advance of losing capacity to refuse treatment in the event that they are judged to lack capacity at some time in the future. An advance decision will have to be followed at the relevant time if it is adjudged to be valid and applicable, even if this means that a person does not have life sustaining treatment and will subsequently die. The mechanisms are as follows:

- An advance decision to refuse treatment can only be made by an adult over the age of 18 with capacity if:

- a. At a later time, a specific treatment is proposed to be carried out by a person providing healthcare and
 - b. At that time the person lacks capacity to consent to that treatment but has made an advance decision to refuse it
- An advance decision to refuse treatment will not be valid if at the material time, the person who made it still has capacity to give or refuse consent to treatment being proposed
 - An advance decision will not be binding or valid if the person had subsequently withdrawn it at any time they had capacity or has done something which is judged to be clearly inconsistent with the advance decision.
 - An advance decision will not be binding or valid if it is not applicable to the treatment being proposed or any circumstances specified in the advance decision are absent or there are reasonable grounds to suppose that circumstances exist which the person did not anticipate at the time of making the advance decision and which would have affected their decision.
 - An advance decision will not be binding if a lasting power of attorney relating to health care is made after the advance decision which gives the attorney donee the authority to give or refuse consent to the treatment to which the advance decision refers.
 - An advance decision is not applicable to life sustaining treatment unless it is verified by a statement to the effect that it is to be applied to the proposed treatment even if life is at risk and the decision is in writing, signed and witnessed. An advance decision which does not relate to life sustaining treatment can be given verbally.

Persons who wish to make an advance decision should be encouraged to register their decision clearly with their health care team or their GP and a clear notice of their advance decision should clearly be recorded within their progress notes and be set out clearly in a care plan.

Criminal Offences

- 3.8 The Act introduces a new criminal offence of ill treatment or neglect of a person who lacks capacity. A person found guilty of such an offence may be liable to imprisonment for up to five years.

Decisions made by others for a person judged to be lacking capacity

3.9 The Act sets out a list of decisions which cannot be made on someone else's behalf when they lack capacity including:

- Consenting to marriage or to a civil partnership
- Consenting to have sexual relationships
- Consenting to a decree of divorce based on two years separation
- Consenting to a dissolution of a civil partnership
- Consenting to a child being placed for adoption or making an adoption order
- Discharging parental responsibility for a child in matters not relating to the child's property or
- Giving consent under the Human Fertilisation and Embryology Act 1990

Interface between the Mental Health Act and Mental Capacity Act

3.10 Professionals may need to think about using the Mental Health Act 1983 to detain and treat for mental disorder for someone who lacks capacity to consent to treatment if:

- It is not possible to provide the care and treatment required for the person without depriving the person of their liberty and this cannot be achieved through using the deprivation of liberty safeguards or an order from the Court of Protection (for example is the person is judged to have capacity to consent to their admission)
- The person requires treatment for mental disorder that cannot be given under the Mental Capacity Act (for example, because they have made a valid and applicable decision to refuse an essential part of the treatment (and see 3.11 below).
- The person needs to be restrained in a way that is not permitted under the Mental Capacity Act.
- The persons capacity is fluctuating
- The person lacks capacity to decide on some element of the treatment for mental disorder but has capacity to refuse treatment for a vital part of it and they have done so or there is some other reason why the person might not get treatment and they or someone else might suffer harm as a result.

3.11 If a person is detained under the Mental Health Act (MHA) 1983, the Mental Capacity Act may not apply to the treatment for the person's mental disorder if they are subject to part IV of the MHA. However an advance decision to refuse treatment or decisions by lasting power of attorney donees or deputies from the Court of Protection may still be valid if they concern treatment for physical disorder unrelated to the mental disorder. Similarly, if the person is judged to lack capacity, best interest decisions by health care staff can be made under the Mental Capacity Act for care and treatment for physical health issues, again unrelated to the mental disorder even though the person is detained under the MHA. Any treatment for a person detained under a short terms section of the MHA to which part IV of the Act does not apply will be carried out under the Mental Capacity Act if the person is assessed to lack capacity. If they are judged to have capacity, the persons consent is the only legal authority to treat them. An assessment of capacity to consent to admission and treatment must be carried out for all newly admitted patients. Further capacity assessments will be made periodically dependent on decisions needing to be made throughout the patients care journey.

3.12 A flow chart is attached at appendix 2 to aid understanding as to which act will be available to be used in differing clinical scenarios. However, situations may arise where both detention under the MHA or a DoLS authorisation or a Court of protection order are available. The choice as to the appropriate legal regime should never be based on a general preference for one regime over another, or a view that one is less restrictive or that one provides greater safeguards. As the nature of the two regimes offer different safeguards, decision makers will wish to exercise their professional judgement in determining which safeguards are more likely to best protect the interests of the patient in the particular circumstances of each case. It will be important for the decision maker to clearly record the rationale for their decision within the patients' electronic records.

4.0 Roles and Responsibilities under the Act

4.1 Decision Makers – the decision maker is determined by the nature and complexity of the decision which needs to be made for a person who lacks capacity. Day to day decisions may be made by a paid or unpaid carer. Complex health and social care decisions (which may include decision about treatment, housing or finances) may be made by health and social care professionals. Doctors will usually be ultimately responsible for medical decisions whilst nurses may be the decision makers in relation to routine care needs.

- 4.2 Lasting Powers of Attorney (LPA's): The Mental Capacity Act allows for a person to appoint two separate types of attorney to act on their behalf if they should lose capacity at some point in the future. These are in relation to either finances (previously known as an 'Enduring Power of Attorney) or health and welfare (including giving consent or refusing consent for treatment. A health and welfare LPA can only refuse lifesaving treatment if provision has been made for this). LPA's came into effect in October 2007 and must be registered with the Office of the Public Guardian before they can be used. This means that the LPA donee will be the surrogate decision maker for a person who has lost capacity and as such their decision must be followed as long as they are acting within the remit of the LPA and are acting in the person's best interest. Any queries or concerns relating to an LPA must be raised with the Mental Health Law department at the earliest opportunity.
- 4.3 Deputies: the Act provides for a system by which the Court of Protection can appoint an individual to make day to day decision for someone who lacks capacity, this will usually be in situations where the Court is unable to make a 'one off' decision to resolve a matter brought before it. The Court can authorise deputies to make both financial and health and welfare decisions and as with the LPA done above, the deputy will be the surrogate decision maker. The process is overseen by the Office of the Public Guardian. Any queries or concerns relating to a deputy must be raised with the Mental Health Law department at the earliest opportunity.
- 4.4 Independent Mental Capacity Advocate (IMCA): The purpose of the IMCA service is to help vulnerable people who lack capacity to make important decisions about serious medical treatment or significant changes of accommodation and where there are no family or friends to consult. An IMCA will have had specialist training on the MCA and in supporting people who lack capacity to establish their feelings and wishes where possible. An IMCA has a right to challenge any decision about the patient's current or planned care or treatment and whether it's in the patient's best interest. The IMCA will not, however be the decision maker in matters relating to treatment and accommodation. An IMCA may also have a role within the DoLS authorisation procedure (see x). The responsibility to make a referral to the IMCA service will be a matter of clinical judgement, advice should be sought from the MHL office if there is any doubt as to whether a referral should be made.
- 4.5 Section 49 (Power to call for reports): Under section 49 of the MCA the Court of Protection can order reports from NHS health bodies and local authorities when it is considering any question relating to someone who may lack capacity and the report must deal with 'such matters as the court may direct.' Most commonly reports are requested because there is a

challenge to a deprivation of liberty authorisation. An order under S49 of the MCA places a legal obligation on the NHS trust to comply, although it is for the trust to determine the appropriate person to complete the report. If any report requests are received from solicitors or local authorities/CCG's, please direct to the Lead Nurse in Mental Health /MHL office in the first instance.

Appendix 1

Mental Health Law Contacts

Corporate

Associate Director of Mental Health Law – 020 7655 4046

Lead Nurse in Mental Health Law – 020 7655 4264

Newham

Mental Health Law Administration – 020 7540 4206

John Howard Centre

Mental Health Law Administration – 020 8510 2136/2134/2133

City & Hackney

Mental Health Law Administration – 020 8510 8418/8107/8286

Tower Hamlets

Mental Health Law Administration – 020 8121 5490/5451/5452

Wolfson House

Mental Health Law Administration – 020 3222 7108/7109

Luton

Mental Health Law Administration – 01582 709601

Beds

Mental Health Law Administration – 01234 310516

Appendix 2

