Mental Capacity Act 2005

Mental Health Training Set
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Mental Capacity Act 2005

Mental Health Training Set

May 2007
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Foreword

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

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

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

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

The new MCA will play an important part in safeguarding and protecting those people in society who lack capacity to do so for themselves. Working in health and social care, you will be playing a vital part in supporting and caring for some of the most vulnerable people in society, and I am confident that you will rise to the challenge posed by the new MCA.
The training is interactive and I know that you will be engaged and stimulated by the material. I hope that the training will leave you with a full understanding of your new role in relation to the MCA, and, most importantly, of your responsibilities to those in your care who lack capacity.

Rt Hon Rosie Winterton MP
Minister of State (Health Services)
1 Introduction

1.1 Who is this training for?

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

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

The materials are designed to cover the knowledge needed by those working with people with mental health needs in a range of health and social care front-line services such as day services, community teams, inpatient services, assertive outreach and early intervention services. The training focuses on how the MCA will be used in practice.

This training can be used in conjunction with the Core Training Set and the PowerPoint presentation on the MCA available at: www.dh.gov.uk/mentalcapacityact

You may also be interested in the training sets aimed at staff in other professional groups or settings. These are:

- acute hospitals
- community and primary care
- residential accommodation.

The training set represents five learning hours for continuing professional development purposes and there is a certificate included in the back of this pack which you can complete and forward to your professional training organisation or employer when you have worked through these materials.
1.2 **Introducing the Mental Capacity Act**

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

**In April 2007:**

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

**In October 2007:**

- all other parts of the Act come into force, including the IMCA service in Wales
- the Code of Practice will have statutory force for all of the Act not solely in relation to where an IMCA is involved and/or the criminal offence

A range of training tools is provided here including case studies and exercises. This is to ensure that the materials can be used by front-line staff in different settings ranging from service users’ own homes to mental health units. All sets of materials are available in hard copy, on CD-Rom and online at: [www.dh.gov.uk/mentalcapacityact](http://www.dh.gov.uk/mentalcapacityact)

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

If you are using the PDF version of this training set you can move around it and to other documents mentioned in the text, such as the Code of Practice, by clicking on the underlined chapter headings or references. Where the PDF features recordings of the service users’ and carers’ quotations you can click on these to hear their words spoken.
In some places, this training set employs language and phrases that are used in the legislation. References to the relevant sections are included in the text. You can find an accessible glossary of relevant terms towards the back of this pack.

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

The MCA is different from the Mental Health Act 1983 (MHA). Some people may be affected by both Acts and this overlap is discussed in this training set. (This training does not attempt to address the changes to the MHA which, at the time of writing, the Government is intending to introduce through its Mental Health Bill.)

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

1.3 Background to the Mental Capacity Act

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

In the past, it was not unusual for some people, for example people with severe or enduring mental health problems, to have decisions made for them. This resulted in numerous injustices, such as mass institutionalisation, forcible treatment, loss of control of their own finances and loss of the right to vote.
1.4 Service users’ and carers’ views

In these training materials, the views of users and carers are included to provide examples of practice issues. The service users who were consulted expressed the hope that the MCA will contribute to the empowerment and protection of people using services. They emphasised how service users who need help when they are in great distress can feel powerless and frightened. They often don’t know how to change things or complain:

Jenny, a mental health service user, told us:

“It’s about empowerment and protection of vulnerable people, or basically people who are in situations where they become vulnerable and don’t necessarily have the capacity or might not have the capacity to make informed decisions themselves. I think they are very good principles. I think they are very good intentions.”

Marcus, father of two young people with severe mental health problems, said:

“The Act, to me, is very important in terms of its principles in that it protects the individual, the carer and the professionals and I think that it is well laid out in terms of this.”

Service users were interested in the relationship between the MHA and the MCA.

Frances, who has been admitted to a mental health unit for assessment, says:

“I think that for someone who has been sectioned under the MHA there might be the fear that the MCA will involve the use of compulsive powers. Under the MHA, for example, individuals with eating disorders can be compelled to eat a prescribed diet, and in the most severe cases nasal fed. This level of compulsion, and with it the feeling of being taken over, is not easily forgotten. If an individual has been sectioned under the MHA they will likely need particular reassurance that the MCA has a different purpose. However, it will also be necessary to point out that should they become so ill that their life is at risk, then similar forms of intervention can be predicted.”

Service users and carers commented that the attitudes and practices of many staff involved will have to change and better communication between service providers and service users will be essential.
Eileen, an older person who has been receiving hospital treatment, said:

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

Karen, who has severe physical disabilities, described the qualities staff need to work with the MCA:

“They’d have to be very patient, be willing to listen, be willing to explore ways to communicate; particularly at that stage when they’re trying to make decisions, they want to be sure they’re making decisions based on what the person lacking capacity would really want, not what the professional thinks might be easier for a friend, social services or whatever.”

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

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

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

Exercise:

What have you heard about the MCA? Do you think it will affect you in your work?

At this point, you have:

• identified which staff will be affected by the MCA
• been alerted to the importance of the Code of Practice.
2 Overview of the Mental Capacity Act

2.1 Person-centred approach

The underlying philosophy of the Mental Capacity Act 2005 (MCA) is to ensure that individuals who lack capacity are the focus of any decisions made, or actions taken, on their behalf. This requires an individual approach that prioritises the interests of the person who lacks capacity, not the views or convenience of those caring and supporting that person. Staff should make every effort to ensure that vulnerable people are helped to make as many decisions as possible for themselves.

2.2 What is mental capacity?

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

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

2.3 Five core principles of the Mental Capacity Act

(Mental Capacity Act, Section 1; Code of Practice, Chapter 2)

The following core principles must be followed in any assessment of or decision about a person’s capacity. Staff who provide health or social care will need to keep a record of all assessments and decisions they have made. This should be included in the person’s file or case notes.
BOX 1

The five core principles

1. A person must be assumed to have capacity unless it is established that they lack capacity.

2. A person is not to be treated as unable to make a decision unless all practicable (doable) steps to help them to do so have been taken without success.

3. A person is not to be treated as unable to make a decision merely because they make an unwise decision.

4. An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in their best interests.

5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

Marian, a carer, said:

“I welcome the assumption in the Act that all people have capacity and that each decision should be viewed on its own.”

Remember, capacity can vary over time and according to what decisions need to be made. People who have a mental illness do not usually lack capacity but may have a temporary loss of capacity to make decisions about their care and treatment. However, it cannot be assumed that because someone has a diagnosis of, for example, schizophrenia, or is in a mental health unit they automatically lack capacity to make such decisions. People who have, for example, brain damage or dementia may well appear to have permanent losses of mental capacity in specific areas, yet here too capacity may fluctuate day to day and alter according to situations such as the time of day or when they have taken their medication.
BOX 2

Example 1

May is an older woman who is normally healthy and active. She lives alone and is in frequent contact with her family. However, a urinary tract infection causes short-term confusion. She is uncertain about where she is and does not recognise her daughter who visits her regularly. For a period of two weeks, she temporarily loses her capacity to make decisions, and while she is unwell her daughter manages her money for her, does the shopping and pays the bills. However, once she has been treated with antibiotics, her confusion clears and she is able to manage her own finances again.

May temporarily lost capacity to make decisions.

Example 2

Bella is homeless. She sleeps in shelters and spends her time pushing a handcart around the city centre. She has an extreme fear of electricity and, as a result of this, has refused all offers of permanent accommodation. Bella develops a problem with her foot. Her community psychiatric nurse (CPN) arranges to take her to see a doctor who diagnoses gangrene in one of Bella's toes. She is referred to a hospital consultant who advises amputation of the infected leg from the knee down. Bella is adamant in her refusal to have the operation. Bella is able to explain that she understands the relevant information about her condition and the consequences of not having the operation to the consultant. She asks her CPN to be with her while she talks to the consultant and refuses the amputation.

Bella's capacity to make a decision varies according to the decision to be made.
Her CPN points out:

“Although Bella has a paranoid fear of electricity that makes it impossible for her to live permanently indoors, she is able to carry on with her life in a manner that suits her. She is perfectly able to make rational decisions about issues other than those related to her fear of electricity. It is important that Bella’s decisions are respected. It was only by getting to know Bella and her circumstances that I knew that the amputation would make it impossible for Bella to walk around the city centre; this was very important to her and for her chosen lifestyle. She would have to be housed, probably in sheltered accommodation of some kind that would have electricity. I don’t think she would have stayed there long and would try to avoid services. This would cause a serious decline in her mental health and seriously impact on the quality of her life. It appeared that the consultant assumed that because Bella has a mental health problem, she lacks capacity in all areas of her life. I expect to see Bella still walking around the city centre, even though her foot will be painful.”

The MCA specifies that a person is not to be treated as unable to make a decision merely because they make an unwise decision. The MCA reinforces the right to autonomy and the fact that each one of us is an individual with our own values, beliefs, preferences and attitude to risk, which may not be the same as other people’s. Even if a person makes a decision which others, including family, friends or staff, view as unwise, unusual or irrational, this does not necessarily mean that the person lacks capacity to make that decision. There may be cause for concern if an individual repeatedly makes unwise decisions, which could place them at a significant risk of harm or serious exploitation. Concern may also be triggered if a person makes a particular decision, which defies all notions of rationality or is markedly out of character.

Karen commented:

“Well, I think everybody has the right to make unwise decisions. A lot of the time disabled people – especially people with learning disabilities – they’re not allowed to make mistakes like the rest of the world. I know a lot of the time it’s because we want to protect people from making silly mistakes, getting into trouble or whatever, but I think you have the right to make mistakes.”
Discussion:

Bella’s capacity to make her own decision was respected, even though it might be viewed as unwise as the gangrene in her toe would be likely to spread to her other toes and leg. Bella’s ability to make this decision was not affected by her mental health problem. How do you think you might have made a record of the decision-making process? How do you think the CPN could best support Bella and communicate with her?

2.4 What is lack of capacity?

(Mental Capacity Act, Section 2; Code of Practice, Chapter 4)

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

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

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

Capacity is both time and decision specific. As a rule, most people will be able to make most decisions most of the time. A lack of capacity can change over time; a person may have the capacity to make some decisions but not others. Most people with mental health problems will have capacity to make decisions most of the time. Do not assume that a person with a mental health problem lacks capacity. Capacity will need to be assessed in relation to the decision being made and in terms of the type of decision being made at the time of that decision.
2.5 Avoiding prejudice in assessing capacity

A lack of capacity cannot be established by a person’s age, appearance, condition or an aspect of their behaviour which might lead to unjustified assumptions about capacity. Anyone making a decision or carrying out an act in the best interests of a person who lacks capacity under the MCA must not make assumptions that cannot be clearly justified. In the case of life-sustaining treatment, the person making the best interests decision must not be motivated by the desire to bring about a person’s death. Avoid letting your own prejudices affect decisions.

Frances, who lives with anorexia, commented:

“Because of their thin or emaciated appearance, individuals with eating disorders could be assumed to have regressed to a ‘child-like mentality’ and need to be treated as one might treat a child in the decision-making process. I have frequently been very child-like in my thinking and expressed wishes, but was able to be ‘adult’ in some areas of my thinking/decision-making.”

Exercise:

Think of some service users you work with who might lack capacity at the moment. Does their capacity vary over time; does it vary according to the decision they are making? What prejudices might you have about their capacity to make particular decisions? How can you avoid letting such prejudices affect judgments about capacity?

2.6 Legal tests under common law and other legislation

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

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

- make a will
- make a gift (although attorneys can also make gifts – see Part 6.2 of these materials)
• enter into litigation (take part in legal cases)
• enter into a contract
• enter into marriage.

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

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

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

### 2.7 Excluded decisions

Other decisions excluded from the MCA include:

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

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

**At this point, you have:**

• learnt how mental capacity is defined
• been introduced to the five core principles of the MCA
• discovered that capacity is time and decision specific
• confirmed the requirement to avoid assumptions and prejudices when assessing capacity and delivering care
• identified those decisions not covered by the MCA.
3 Using the Mental Capacity Act in the community

3.1 Assessing capacity to make a decision in community settings

When care or treatment in the community is proposed, staff should make an assessment of whether a person does or does not have capacity to consent to care or treatment. This is essential if any kind of physical intervention or restriction of liberty is proposed. Staff cannot know whether they are acting with or without the person’s consent if they do not do this assessment. If they are acting without the person’s consent, they will be doing so on the basis of the Mental Capacity Act 2005 (MCA) or, in some cases, the Mental Health Act 1983 (MHA).

Assessment of capacity to make a decision is therefore an integral part of any assessment about mental health care or treatment. You should assume a person has the capacity to make a specific decision unless there is evidence to show otherwise. Any relevant preliminary screening forms or standardised tools should include questions that consider matters of capacity. The trigger for an assessment of capacity is that a decision has to be made.

BOX 3

Example

Mrs O’Brien has been receiving regular visits from the community nurse who has been treating her leg ulcer. However, she increasingly seems confused and does not appear to recognise the nurse when she calls. After a month of regular visits, she stops letting the nurse in, saying she has been sent to spy on her by MI5. Mrs O’Brien refuses treatment for her leg ulcer. The nurse is concerned that Mrs O’Brien’s confusion is affecting her ability to make this decision about treatment and decides to apply the two-stage test of capacity shown in Box 4.
There are two questions to be asked if you are assessing a person’s capacity to make a decision (see Box 4).

**BOX 4**

**The two-stage test of capacity**  
(*Code of Practice, 4.11–4.13*)

“1. Is there an impairment of, or disturbance in, the functioning of the person’s mind or brain?

If so

2. Is the impairment or disturbance sufficient that the person lacks the capacity to make that particular decision?”

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

It is important to remember that an ‘unwise decision’ made by the person does not in itself indicate a lack of capacity, as in Bella’s case.

The assessment process has to be clear and accountable. It may require input from staff in the range of organisations involved in providing support and should include family and carers. Where there is no family or carer, or other person authorised to make decisions for that person, an independent mental capacity advocate (IMCA) may be assigned if there is an important decision about certain medical treatment or a change of accommodation to be made (see Part 5.1 of these materials). Other advocates may also be able to offer support, representation or advice and staff need to know the local services and how to contact them.

Anyone who is being assessed for capacity should be assessed at their best level of functioning for the decision to be taken. Be aware that circumstances may change and an assessment of capacity may have to be repeated or reviewed, over time and for different decisions.
The list in Box 5 shows the range of areas to be considered. As always, the range of areas to be assessed will be specific to the individual and their circumstances and the two-stage test of capacity must be applied.

**BOX 5**

**Factors to be considered in assessing capacity:**
- general intellectual ability
- memory
- attention and concentration
- reasoning
- information processing – how a person interprets what they are told
- verbal comprehension and all forms of communication
- cultural influences
- social context
- ability to communicate.

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

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

**Key questions to consider when assessing capacity:** *(Code of Practice, 4.44–4.49)*
- Does the person have a general understanding of what decision they need to make and why they need to make it?
- Do they understand the consequences of making, or not making, the decision, or of deciding one way or another?
- Are they able to understand the information relevant to the decision?
- Can they weigh up the relative importance of the information?
- Can they use and retain the information as part of the decision-making process?
- Can they communicate their decision?
It is important that all people involved in assessing a person’s capacity should understand the nature and effect of the decision and any actions relating to the assessment.

Look at your assessment documentation and think about how you assess a person who uses your services. When could you introduce questions about a person’s capacity to make particular decisions?

3.2 Acting in people’s best interests

The MCA requires any decision or act made on behalf of a person who lacks capacity to be made in that person’s best interests. Decisions may be made under the MCA by people appointed to do so, such as attorneys, deputies and the Court of Protection. However, decisions will often be made by staff involved in the care and treatment of the person concerned. Staff can also undertake most acts in connection with care or treatment which are made on behalf of a person who lacks capacity to consent if they reasonably believe those acts are in the person’s best interests.

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

Acts in connection with care and treatment

(Mental Capacity Act, Section 5; Code of Practice, Chapter 6)

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

• have taken reasonable steps to assess the person’s capacity to consent to the act in question

• reasonably believe that the person lacks the capacity to consent

• reasonably believe that the act they are carrying out is in the person’s best interests.

However, staff will not be protected if they act negligently.
The member of staff who delivers care or treatment to someone who lacks capacity to consent to it is the **decision maker** even if a number of professionals in a multidisciplinary team have been involved in the decision. Where nursing care is provided, the nurse is the decision-maker.

Staff do not always realise when they are deciding on the appropriate care and treatment in the best interests of a person who lacks capacity to make that decision. Many of these decisions are day-to-day ones that staff are already making on behalf of service users.

**BOX 6**

**Example**

On any given day, an older person with dementia who lives at home may have help with breakfast from a family member in the morning, be taken to the community centre in the afternoon for bingo by a community volunteer, and have help from a support worker with shopping every Thursday. Each of these individuals, provided they have taken reasonable steps to see if the person lacks capacity to consent to the action they propose to take, and they are acting in the person’s best interests, would be protected from any liability in relation to what they are doing under Section 5 of the MCA.

**Acts in connection with personal care may include:**

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

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

**BOX 7**

Denise has a diagnosis of schizophrenia and, following a lengthy hospital admission, is now living in her own flat in the community. She receives a programme of support under the Care Programme Approach. This includes regular visits from Sandra, a support worker, who helps her keep her flat clean and tidy and manage her money and shopping. Denise often buys food that she then decides she won’t eat but is unwilling to throw it out once it has ‘gone off’, despite advice from Sandra. On this occasion Sandra judges that Denise lacks capacity to consent to practical support and advice with hygiene. She makes a best interests decision and empties the fridge of decaying food and puts it in the rubbish bin outside, despite Denise’s insistence that she should leave the food where it is. She tells Denise not to touch it. Sandra makes a note in the case file that, on this occasion, she made a best interests decision.

The steps that should be taken to assess best interests will vary according to individual circumstances. However, the MCA (Section 4, Code of Practice, Chapter 5) sets out a checklist of common factors which must always be taken into account in any situation where an action is being undertaken or a decision is being made or for a person lacking capacity (see Box 8). Staff must be confident that they have made every effort to work out what might be in the best interests of the person.
BOX 8
The factors that need to be taken into account when determining what is in someone’s best interests are set out in the best interests checklist:

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

Source: Mental Capacity Act, Section 4; Code of Practice, Chapter 5

Other good practice points include:

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

Think about how this checklist might apply to Denise. For example, Sandra should not assume that she should regularly empty the fridge for Denise but should check her capacity to make her own decisions about food hygiene on future visits.

3.3 Using the Mental Capacity Act and the Mental Health Act to treat people who lack capacity to consent to treatment

The MCA can be used to treat people with mental health problems who lack capacity to consent. This applies to treatment for mental health problems, regardless of how serious they are, as well as physical health problems. The MCA cannot be used to detain people or deprive them of their liberty.

In some cases, both the MCA and the MHA will be options for those who are judged to need treatment, but the MCA can only be used for people who lack the capacity to make their own decision about treatment. The MCA will usually represent the less restrictive option. However, the MHA may need to be used when professionals judge the use of the MCA not possible or inadequate in the circumstances.
It might be necessary to consider using the MHA rather than the MCA if:

- it is not possible to give the person the care or treatment they need without carrying out an action that might deprive them of their liberty
- the person needs treatment that cannot be given under the MCA (for example, because the person has made a valid and applicable advance decision to refuse all or part of that treatment)
- the person may need to be restrained in a way that is not allowed under the MCA
- it is not possible to assess or treat the person safely or effectively without treatment being compulsory (perhaps because the person is expected to regain capacity to consent, but might then refuse to give consent)
- the person lacks capacity to decide on some elements of the treatment but has capacity to refuse a vital part of it – and they have done so, or
- there is some other reason why the person might not get the treatment they need, and they or somebody else might suffer harm as a result.

Source: Code of Practice, 13.12
BOX 10

Example 1

Cynthia has a bipolar disorder which is managed in the community by lithium treatment and ongoing support from Brian, a CPN. Her daughter is getting married in two months time and she is becoming increasingly agitated and ambitious in her planning for the event – she has already taken out large loans which she cannot afford and is up all night making lists and ringing hotels. Her psychiatrist suggests adding a major tranquilliser to her medication, but Cynthia says that she needs to have lots of energy to plan the event and is concerned that the tranquilliser will slow her down. The psychiatrist consults Brian and decides that Cynthia currently lacks the capacity to consent to treatment but that he can administer a tranquilliser to her under the MCA without her consent. He considers that treating her now will be in her best interests as otherwise she is likely to miss or disrupt the wedding, which would be a huge disappointment for her and her family.

Example 2

Keith, who has a history of psychotic episodes, is becoming increasingly anxious about the CCTV cameras in supermarkets which he feels are recording his every move. Jasmine, his CPN, is concerned that, although he appears to be managing other aspects of his life well, he has become embroiled in a number of angry arguments in his local village supermarket. Keith refuses to have his medication increased as he is unhappy about possible side-effects. Jasmine is aware that Keith’s history of violent behaviour means that he may pose a risk to others and arranges for him to be assessed for admission to a mental health unit under the MHA. She considers that a short admission would allow for a full assessment and review of his medication.

Comment:

The MCA allows Cynthia, who is judged to lack capacity to consent to treatment, to be treated in the community without restriction of her liberty. In Keith’s case, there are risks to other people if he continues to refuse treatment and he does not appear to lack capacity to consent to treatment. The MHA is therefore the appropriate means of delivering care and treatment.
3.4 The Mental Capacity Act and guardianship under the Mental Health Act

The MCA can be used to deliver care or treatment to service users in the community in circumstances where previously practitioners might have used powers of guardianship (MHA, Section 7). The MCA should be the first option considered. However, guardianship might be considered as an option in the following circumstances:

- where decisions about where a person lives are placed in the hands of a single professional over a continuing period, for example when there have been long-running disputes about where the person should live
- where the person is thought to be likely to respond well to the authority of a guardian
- where explicit authority is needed to return the person to the place where they live; for example, someone is required to return to the hostel which they have left.

At this point, you have:

- been introduced to the two-stage test of capacity
- identified what needs to be considered when assessing capacity
- been introduced to the best interests checklist
- identified when the MCA can be used to deliver treatment in the community
- confirmed that the MCA can be used in place of guardianship in some cases.
4 Using the Mental Capacity Act and the Mental Health Act in relation to inpatient admission, treatment and discharge

This section explores further some of the interfaces between the Mental Capacity Act 2005 (MCA) and the Mental Health Act 1983 (MHA). A quick reference guide to some of the main provisions of the MHA is available in Appendix 2.

BOX 11

Summary of the two Acts

The MCA provides a framework for acting and making decisions on behalf of people of 16 years and over who lack the capacity to make decisions for themselves. The Act confirms in legislation the presumption that adults have full legal capacity to make their own decisions unless it is shown that they do not.

The MHA is primarily about people who are diagnosed as having a mental disorder that requires them to be detained and treated in the interests of their own health or safety, or with a view to protecting other people.

People who are detained under the MHA do not necessarily lack capacity to make decisions either about their mental healthcare or anything else. Even if they do lack capacity to make treatment decisions they may still have the capacity to manage their day-to-day affairs. They may be able to make decisions about their financial affairs and other matters. Their capacity to do this should be assessed in relation to the particular decision.

4.1 Applications under the Mental Health Act

The principle that capacity is decision specific needs to be kept in mind when assessing people to decide whether an application should be made under the MHA. Even though formal admission under the MHA is being considered, people may have the capacity to make some decisions.
BOX 12

Example

Mrs Kolakowska’s family are very concerned about her welfare. She lives in sheltered accommodation, and has a long history of depression, but she now seems to believe that she still lives in her former family home. She is very distressed and keeps asking neighbours to take her home, and has recently taken an overdose of medication. The neighbours have contacted the GP because Mrs Kolakowska has now started to bang on their windows during the early hours of the morning asking for help.

An approved social worker (ASW) has assessed Mrs Kolakowska and feels, together with the GP, that a period of assessment in an inpatient specialist mental health unit is needed because Mrs Kolakowska is at risk (the overdose of medication is evidence of this) and appears to have a recurrence of her mental health problem. As she now lacks the capacity to consent to an admission and needs to be detained in order to be assessed and treated, the MHA and not the MCA needs to be used.

It is decided to admit Mrs Kolakowska to the inpatient unit for assessment under Section 2 of the MHA. Although initially resigned to going to hospital, Mrs Kolakowska becomes very distressed about the care of her cats while she is away.

A neighbour offers to look after the cats, as she has done on many previous occasions. Mrs Kolakowska gives her neighbour £50 to cover the cost of cat food. The ASW records in the notes that, although she is being admitted to hospital under the MHA, her decision to give her neighbour money is being made with capacity. In this case, based on what the ASW has witnessed, it is not necessary to consider taking any further action to help Mrs Kolakowska to manage her day-to-day financial decisions, just because she is being admitted to hospital under the MHA – although there will be some cases where that will be necessary.

Being admitted to hospital under the MHA does not mean that people have lost the capacity to make all (or even any) decisions.
You must always bear in mind the five core principles and ensure that no one is considered to be unable to make a decision unless all practical steps to help them have been exhausted and shown not to work. Service users should be involved in the decision-making process and staff should facilitate their involvement wherever possible.

Steps to be taken in helping people to make a decision:  
(Code of Practice, 3.0–3.16)

- Provide all relevant information but do not burden the person with more detail than required. Include information on the consequences of making, or not making, the decision. Provide similar information on any alternative options.

- Consult with family and other people who know the person well on the best way to communicate, e.g. by using pictures or signing. Check if there is someone who is good at communicating with the person involved.

- Be aware of any cultural, ethnic or religious factors which may have a bearing on the individual. Consider whether an advocate (you will see in Part 5.1 of these materials that an IMCA is only likely to be involved in a limited number of cases, so we mean a general advocacy service here) or someone else could assist, e.g. a member of a religious or community group to which the person belongs.

- Make the person feel at ease by selecting an environment that suits them. Make sure it is quiet and unlikely to be interrupted. Arrange to visit relevant locations; for example, if the decision is about a hospital or short-break stay, visit the place with them. See if a relative or friend can be with them to support them.

- Try to choose the best time for the person. Try to ensure that the effects of any medication or treatment are considered. For example, if any medication makes a person drowsy, see them before they take the medication, or after the effect has worn off.

- Take it easy. Make one decision at a time, don’t rush and be prepared to try more than once.
Exercise:
Go back to the example of Mrs Kolakowska. How would you best communicate with her? Would you check, for example, that she was able to hear you? Is English her second language and might she need an interpreter’s help when she becomes distressed? Or might she like to have someone present she can trust, such as a family member, a neighbour, the local priest or the housing manager? Are there times of the day when she feels better?

Assessment of capacity may be required for people subject to the MHA when certain decisions need to be made. These decisions could be major decisions relating to financial affairs, legal matters, consent to treatment, or the place where a person lives; or they could be day-to-day decisions.

4.2 Using the Mental Capacity Act as a less restrictive alternative to the Mental Health Act

The MCA can be used to admit people to inpatient care when they lack the capacity to consent to admission and admission is judged to be in their best interests, but it cannot be used to detain them in hospital. They should not be assumed to lack capacity to consent just because they refuse to be admitted to hospital.
Mrs Owen, who is disabled, is very distressed when she discusses her husband’s behaviour with the practice nurse. Mr Owen, who is 73, hard of hearing and physically frail, is increasingly anxious about his money. He frequently rings for a taxi to take him to an ATM to withdraw money, and on several occasions he has lost both money and cash cards; several cash cards have been lost in a single month. When this is discussed with Mr Owen, he gets very upset and tearful, apologising profusely and promising not to repeat his behaviour. Mrs Owen feels helpless in this situation. The practice nurse contacts the GP who arranges for an assessment by the community psychiatric nurse (CPN) service.

Suspecting underlying depression and feeling that Mrs Owen may need a break, the CPN suggests that an admission to hospital for assessment and medical tests may be helpful. The CPN assesses Mr Owen as having the capacity to consent to voluntary admission but Mr Owen is not prepared to be admitted to hospital as he does not want to leave his wife on her own at home. It is therefore arranged for Mr Owen to be assessed at the local mental health unit as a day patient. With the use of a new hearing aid, it is possible to assess Mr Owen and it becomes clear that he is suffering from depression and possibly early stages of dementia.

Comment:

Mr Owen’s behaviour should not automatically lead to the conclusion that he lacks capacity to consent to hospital admission. Nevertheless, if Mr Owen had been assessed as lacking capacity to consent to admission, it might have been possible to use the MCA to admit him if admission was considered to be in his best interests. However, the MCA could not have been used if the effect of the admission would have been to deprive Mr Owen of his liberty (see Part 7.2 of these materials).
4.3 Delivering day-to-day care to inpatients under the Mental Capacity Act

Best interest decisions can be made to deliver day-to-day acts of care to inpatients who lack capacity to consent to particular acts.

**BOX 14**

**Example**

Lillian, aged 81, is admitted informally to an inpatient mental health unit. She is very confused and has spent four weeks on her settee at home, refusing to move. She has not washed for some time and is very dirty. Lillian agrees to take a bath but, even after a hairwash, her long hair is very matted and impossible to tidy as she does not want anyone to brush it. The ward sister assesses Lillian as lacking the capacity to agree to a haircut and takes a best interests decision to have Lillian’s hair cut for her. Staff talk to Lillian while she has her hair cut and show her how much better it looks afterwards.

4.4 Treatment for a physical condition

If an individual detained under the MHA needs treatment for a physical condition and there is a question about whether they have capacity to consent to it, their capacity should be assessed in accordance with the MCA. If they are found not to have capacity to make their own decision, then consideration should be given to what is in their best interests.
Example

Elizabeth has been detained in hospital under the MHA for a number of years. She is diagnosed with breast cancer and advised to have a mastectomy (removal of the breast) followed by chemotherapy and radiotherapy treatment. She refuses both the mastectomy and the chemotherapy. Although Elizabeth is detained in order to receive care and treatment for her mental disorder, an assessment of capacity by her psychiatrist and a psychologist confirms that she is not lacking capacity to make decisions about her physical health care. She is able to explain to the oncology consultant that she knows the risks.

Exercise:

How would you explain this to the ward staff if you were the medical practitioner involved in this case?

In other instances an individual will lack capacity to consent to or refuse treatment for a physical condition by reason of their specific mental disorder. Professionals have a duty of care to consider taking a decision about physical health in the service user’s best interests.
Example

Miss Wang is currently in hospital receiving treatment under Section 3 of the MHA. Miss Wang has a diagnosis of paranoid schizophrenia, and experiences delusions and hallucinations. She has a long history of treatment for mental health problems, but refuses all medical treatment, regarding it as unnecessary and part of a plot against her. Miss Wang has recently developed an unusual swelling of her stomach and was persuaded by staff to cooperate with an ultrasound scan, which revealed suspected ovarian carcinoma (cancer). The oncology consultant believes that a CT scan is essential for the proper investigation and treatment of the carcinoma and has informed her family of this, but Miss Wang refuses to consent to a general anaesthetic or any further medical procedures. Miss Wang is assessed as lacking capacity to consent to or refuse treatment currently under the MCA's two-stage test of capacity, on the basis that her mental illness causes an inability to understand the information regarding the need for treatment or to use or weigh that information in order to reach a decision. The MHA is irrelevant here, but under Section 5 of the MCA doctors are able to provide treatment in the absence of consent, so long as the principles of the MCA have been complied with and the treatment is in Miss Wang's best interests.

Discussion:

The two cases of Miss Wang and Elizabeth are different. Miss Wang, because of her specific mental health problems, lacks capacity in this instance. This is because of the nature of her problems (such as her paranoid feelings) and how they are shown in a thought disorder that is particularly related to medical treatment. On the other hand, Elizabeth’s specific mental health problems have no impact on her capacity to make the decision about the treatment options for breast cancer.

4.5 Consent to treatment for mental health problems

Both the MHA and the MCA require the person proposing to treat to establish an individual’s capacity to consent to treatment. People with mental health problems who are not detained under the MHA may be treated under the
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MCA on the same basis as anyone else, if they lack capacity to make the relevant decisions for themselves. However, if a person is formally detained under the MHA, then, subject to various safeguards, it may be possible to treat their mental disorder without their consent (whether or not they have the capacity to give such consent). In many cases, treatment for mental health problems can only be given without consent if a second opinion doctor (SOAD) has certified that it should be given, and if the patient is refusing consent, or is unable to give it.

The MCA does not apply to treatment for a mental disorder given under Part IV of the MHA.

BOX 17

Example

Tyrell has been admitted to a mental health unit under Section 2 of the MHA. He has a long-term diagnosis of schizophrenia with delusions of persecution. However, he has the capacity to make decisions about his treatment. His psychiatrist, who has treated him previously, wants to start Olanzapine immediately as part of his treatment regime. Tyrell says that he is not happy with this as he has taken it before and it gave him a rash. However, the psychiatrist considers that other treatment options have been exhausted. Tyrell has had numerous admissions under the MHA over the last five years, and has responded well to Olanzapine in the past. The psychiatrist decides to go ahead and treat Tyrell despite his objections.

Comment:

As Tyrell is detained under a section of the MHA, the psychiatrist can treat him for his mental disorder without his consent. After the first three months, a SOAD must certify whether or not the medication should be given, and his permission or refusal should be recorded in the case notes. The psychiatrist must consider whether to proceed in the absence of Tyrell’s consent, to give alternative treatment or no further treatment. (MHA Code of Practice, Chapters 15 and 16.)
4.6 Using the Mental Capacity Act in planning discharge from hospital

Regardless of whether or not a person is detained under the MHA, the individual’s capacity to make decisions needs to be considered in planning for discharge from hospital or an assessment unit.

BOX 18

Example

Donald is 30 and has a long history of schizophrenia. He has recently been detained under the MHA and treated in a specialist inpatient unit following a severe episode. Most of his symptoms are now under control but he is still anxious and becomes paranoid about his money. The multidisciplinary team considers that Donald is ready for discharge to his new housing association flat. The occupational therapist considers that a support worker needs to visit regularly to help Donald with cleaning, budgeting and cooking. Donald is well enough to leave hospital but he refuses to agree to visits from a support worker as he is sure that they will steal his money.

The key worker recognises that Donald is extremely frightened of new people and lacks the capacity to make the decision about accepting support. He does not understand the consequences of not receiving help with his flat and daily living. She discusses this with him and makes a decision to immediately commence the visits from the support worker so that his flat is not neglected and to ensure he has food and anything else that he needs from the point of his discharge. She records this in his care plan.

Comment:

Staff may find it harder to define social care that is provided in a person’s best interests because they lack capacity to consent than the more obvious medical or health treatments or interventions (see Code of Practice, 6.5, personal care).

The support worker will be protected from liability, for example when shopping for Donald, as long as Donald lacks the capacity to consent to those and other aspects of his personal care being provided for him by the support worker and the support worker reasonably believes that those acts will be in Donald’s best interests.
Anyone making a decision in the best interests of a person who lacks capacity is required by the MCA not to make assumptions that cannot be clearly justified. They are also required to involve the person in the decision-making process. They must encourage and enable their participation wherever possible.

4.7 Aftercare under supervision  
*(Mental Health Act, Section 25A)*

Where previously professionals might have considered using supervised aftercare for a person being discharged from a mental health unit, the MCA might now be used to deliver care and treatment. You should consider whether the MCA applies – but remember, the MCA can only be used when service users lack the capacity to make particular decisions. If Donald had been considered to have capacity to make the decision about seeing his support worker but was unwilling to allow her access, then aftercare under supervision might have been an option if there was a substantial risk of serious harm to Donald or others (Code of Practice, 13.22–13.25).

At this point, you have:

- noted that under the MCA you assume a person has capacity and that people with a mental health problem must be assumed to have capacity until it can be proved otherwise
- identified instances where people with mental health problems are able to make decisions about care and treatment for physical health problems
- confirmed that people detained under the MHA can be treated compulsorily regardless of their capacity.
5 Advocacy, disagreements and recording

5.1 Independent mental capacity advocates
(Mental Capacity Act, Sections 35–41; Code of Practice, Chapter 10)

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

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

The duties of an IMCA are to:

• support the person who lacks capacity and represent their views and interests to the decision maker

• obtain and evaluate information, both through interviewing the person and through examining relevant records and documents

• obtain the views of professionals and paid workers providing care or treatment for the person who lacks capacity

• identify alternative courses of action

• obtain a further medical opinion, if required

• prepare a report (that the decision maker must consider).

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

Similarly, the regulations also allow IMCAs to contribute to reviews for people who have been in accommodation arranged by the local authority or NHS body or who have been in hospital for more than 12 weeks and who have nobody else to represent them.
The local authority or NHS body may instruct an IMCA to represent the person lacking capacity in either adult protection cases or accommodation reviews if they consider that it would be of ‘particular benefit’ to the person.

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

**BOX 19**

**IMCAs always represent the interests of:**

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

**IMCAs may represent the interests of:**

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

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

In England, the local authority area where a person currently is (e.g. in hospital) is responsible for making the IMCA service available. In Wales, Local Health Boards have this responsibility. If the decision is about treatment, the relevant NHS body must instruct an IMCA, if it is about a move it will be either the local authority or the NHS body.
For people detained under the MHA:
(Code of Practice, Chapter 13)

- an IMCA is **not** required in relation to serious medical treatment given under the MHA for the person’s mental disorder

- an IMCA is **not** required if the patient has to live in a particular place while on leave or as a result of a requirement imposed under the MHA, such as a guardianship or supervised discharge order.

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

Exercise:

You might like to think about Bella (see Part 2.3 of these materials). Bella might be in the category of people who are entitled to an IMCA. How would you introduce the idea to her?

5.2 Helping people with decision making

It is important that staff provide people with information about their rights. People need to know about their options. Staff need to find the time to give explanations and to answer questions. They should try to establish a dialogue and get to know the individual’s circumstances. It might not, for example, be appropriate to make major decisions if the person is highly disturbed or distressed. People often need time to settle after admission to hospital or a care home. Staff should give people time to recover from treatment and take the possible effects of medication into account.
For many people it is very hard to accept that someone has made a decision in their best interests. Frances explained what it was like for her to have decisions made on her behalf while being treated under the MHA for an eating disorder, that was at the time a life-threatening mental health problem. She also acknowledged the difficulties for nursing staff:

“One example is that of not being allowed to go out for a walk during the early stages of specialist treatment. I was, almost literally, crawling up the walls with the distress of not being able to exercise. I was very sulky over the issue and therefore not a co-operative patient for the nursing staff. If I was a practitioner I would find it hard to go against the person’s wishes to ensure their best interests. Another example, again in the specialist unit, was the locking of the fridge for a period of a week or two. Most of us were furious that we were not allowed access to our milk to make a drink without the presence of a nurse. The action had been taken to avoid milk being thrown away or tampered with, but the indignation and belittlement we felt were enormous and we vehemently conveyed this to the nursing team. Standing firm in such a situation must have again been difficult for the nursing staff.

“When I was severely ill I was capable of making decisions on some areas of daily living, but not on others where irrational thinking was dominant. I outwardly appeared articulate and able to express likes, dislikes, and so on, but the majority of these were dictated by how I was thinking. I also had the capacity to lie and provide sufficient justification to back up my assertion. For example, I claimed to be allergic to dairy products, despite the fact that I was seriously ill with anorexia nervosa and TB and a dairy intake would have benefited my recovery. I only admitted I was lying when I was offered a more gruesome calorific alternative by a dietician with specialist knowledge of eating disorders.”

5.3 Disagreements and how they might be resolved

Sometimes there may be disagreements between people about decisions. While the Court of Protection (see Part 9 of these materials) has a role in resolving major disputes, it will only consider cases when all other dispute resolution services have been tried unsuccessfully.
5.4 Recording decisions about capacity

All professional staff – that is, social workers, care managers, nurses, doctors and others – involved in the care and treatment of a person who may lack capacity should keep a record of long-term or significant decisions made about capacity. The record should be made in the place where you regularly record details about a service user or patient such as a care plan, file or case notes. The record should show:

- what the decision was
- why the decision was made
- how the decision was made
- who was involved
- what information was used.

Recording decisions in this way will help staff to demonstrate why they had a reasonable belief in the person’s lack of capacity.

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

For example, Mrs Hussein has been admitted for assessment to a mental health unit because of apparent memory loss and serious concerns about self-care. She needs to be helped when taking a bath, taken to the toilet and helped to go to bed at night. It is not necessary to record a capacity assessment on every occasion. However, her care plan should show that her capacity to make decisions about these activities has been assessed and that such decisions are being made in her best interests and that they will be regularly reviewed, unless or until she gains capacity. This may be a role for the ward sister or a joint role with the key or named nurse, and communication with Mrs Hussein needs to be part of the plan.
**Exercise:**

You might want to use a particular case you have been involved with to discuss the following with your colleagues or think about what you would do:

- What day-to-day decisions would need to be included in the care plan?
- Who would write the care plan?
- Who would be involved in the review of the care plan?
- How often would the care plan need to be reviewed?

It is advisable to make notes of new decisions in a person’s file or case notes. This applies even to those day-to-day decisions which might not previously have been recognised as a decision about capacity. For example, if Mrs Hussein’s condition deteriorates, she may need help with eating and drinking. This would need to be noted in her case notes or file and her care plan adjusted accordingly, with her cultural preferences noted and observed.

At this point, you have:

- identified who an IMCA can represent
- developed an understanding of the role of an IMCA
- noted the importance of resolving disputes informally
- appreciated the need to record decisions about capacity.
6 Planning for future care and treatment

The Mental Capacity Act 2005 (MCA) makes provision for future decision making for when a person may lack capacity. This includes:

- Advance decisions
- Lasting Power of Attorney (LPA)

6.1 Advance decisions to refuse treatment

(Mental Capacity Act, Section 24–27; Code of Practice, Chapter 8)

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

An advance decision to refuse treatment enables an adult to make treatment decisions in the event of their losing their capacity at some time in the future. Such a decision properly made is as valid as a contemporaneous decision (made at the time) and so it must be followed, even if it results in the person's death. If an advance decision involves refusing life-sustaining treatment, it has to be put in writing, signed and witnessed but, otherwise, advance decisions can be verbal.

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

An advance decision to refuse treatment can be overridden by the Mental Health Act 1983 (MHA), if the person is detained under the MHA and could be treated under that Act without their consent even if they had capacity to refuse it at the time in question. The fact that a patient has refused treatment – at the time, or in advance – is an important factor to be taken into account, but will not ultimately determine whether the treatment in question should be given. However, when the advance decision concerns refusal of treatment for a physical health problem, the MHA is not relevant and the MCA applies.
Jenny, a mental health service user, said:

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

**BOX 20**

**Example**

Mr Rogers was 73 years old when he received a diagnosis of vascular dementia. While he still had capacity, he was able to discuss his future care with his family. He was able to make an advance decision to refuse intrusive medical treatment to preserve his life, such as emergency resuscitation, when, in the future, he lacked capacity. Two years later, Mr Rogers suffered a massive stroke. Conservative medical treatment, including maintaining fluids, was provided to help keep him comfortable. Mr Rogers never recovered but his refusal, as stated in the advance decision, was followed.
Example

David is a 60-year-old single Jewish man with a long-standing diagnosis of bipolar disorder. According to his community psychiatric nurse (CPN), his problems are predominantly related to episodes which involve aggressive and destructive behaviour in the community, elation of mood, grandiose delusions and delusional religious thoughts. David has had many hospital admissions, most of which have been compulsory admissions under the MHA. He has been treated with a wide range of neuroleptic medication.

David has no close living relatives. Earlier this year he made an advance decision in writing, which states that in the event of his becoming unwell and lacking capacity he wishes to withhold consent for treatment using electroconvulsive therapy (ECT). David's reasoning for this was that the use of such treatments causes him to resent mental health services. He has also asked for the following to be taken into consideration:

- his need for Kosher food while in hospital
- his difficulty swallowing and need for water with food
- his need to attend service user meetings
- when he becomes unwell in a public place, his need for the help of his care co-ordinator.

However, David becomes profoundly depressed and does not respond to antidepressant medication. He is admitted to hospital under Section 3 of the MHA, after it is decided that the only way of ensuring that he complies with treatment is to detain him in hospital. ECT is considered as a treatment option because, on previous occasions when he was very severely depressed, David has responded well to this form of treatment.

After discussions between the care team and David's advocate, the doctor decides to override the advance decision and give David a course of ECT. A second opinion will be needed as David does not have the capacity to consent.

The care team is, however, able to comply with David's other requests. It is agreed that the CPN will explain later to David why the advance decision was not accepted. Staff record why they thought it was reasonable to override David's advance decision.
Decision makers must be able to recognise when an advance decision to refuse treatment is both valid and applicable. Protection from liability will not apply if a valid and applicable advance decision is ignored.

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

An advance decision is valid when:

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

An advance decision is applicable when:

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

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

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

But an advance decision is not applicable if there are reasonable grounds for believing that circumstances now exist which the person did not anticipate at the time they made the advance decision and which would have affected their decision had they been able to anticipate them (e.g. new treatment), or if they have behaved in a way that raises doubts about or contradicts their advance decision.
As part of the empowering of service users, care staff need to develop means of promoting, implementing and recording this form of advance planning. For example, many Mental Health Trusts and voluntary groups are developing guidance on the use of advance decisions.

Exercise:

Think about your own health care in the future. Are there aspects of treatment you might not want to receive? How would you describe the circumstances under which you would want treatment to be withheld? How would you feel if the decision was not upheld?

6.2 Lasting Powers of Attorney (LPA)
(Mental Capacity Act, Section 9–14; Code of Practice, Chapter 7)

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

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

Isabel said:

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

What is a Lasting Power of Attorney?

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

• personal welfare, including healthcare
• property and affairs (financial matters)
The person making the LPA is the **donor**, who donates or hands over responsibility to make decisions under specified circumstances. The person appointed to make the decisions under the LPA is the **donee**, also known as the **attorney**. There are some restrictions depending on the type of LPA: for example, there are restrictions on gifts (see page 50 of these materials). One attorney may hold a number of LPAs for different people: for example, a daughter can have LPAs for both her parents, or a bank official can have LPAs for a number of clients. A person can choose one or a number of people to hold their LPA, such as a partner and adult children.

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

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

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

**Who can be an attorney?**

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

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

“Individuals will come to see that the MCA can be used as a means of increasing a positive sense of control. The individual will often be able to appoint an LPA and make an advance decision if they so wish, both empowering mechanisms. Indeed it may well be useful for a practitioner to remind the individual of the purpose of the Act, and that this includes the aim of empowering the individual.”

Ade, who is retired and has an adult child with mental health problems, commented:

“The LPAs, not specifically to me, but to people who have property and people who have children and who are elderly may find themselves in a situation where if they know that their mental capacity will be threatened in later life, if they will suffer from Alzheimer’s disease and diseases of old age it would be helpful if they could make a will beforehand ... or if they could appoint LPAs or whoever to look after their affairs this I think would be very, very helpful for them. It will avoid confusion and bickering among the family.”

More than one individual may be appointed to act either separately or together.

**BOX 22**

**Example**

Helen and Susan have been partners for the last twelve years. Helen has retired from her job as a teacher because of severe depression. At times, Helen’s depression becomes so severe that she is unable to deal with bills. Helen knows that she is likely to have future episodes of severe depression. When she is well, she asks Susan to act as her attorney to make decisions about her finances on her behalf should she lack the capacity to do so in the future, and they register a personal welfare LPA, also appointing Susan to refuse drug treatment on her behalf in the event of it being suggested by professionals. They are aware that Susan would not be able to refuse drug treatment for Helen’s depression were Helen to be detained under the MHA. Helen ensures Susan knows this so that she does not feel that she is letting her down if medication is administered.
Powers of and limitations on LPAs

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

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

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

Enduring Powers of Attorney

*(Mental Capacity Act, Schedule 4; Code of Practice, Chapter 7)*

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

• identified when an advance decision is valid and applicable

• discovered that a valid advance decision refusing life-sustaining treatment must be in writing, signed and witnessed

• learnt when an LPA is valid

• identified who can be an attorney

• discovered that LPAs can be used for a variety of decisions but cannot be used to demand specific care or treatment

• confirmed that existing EPAs will continue to be valid.
7 Limitations on restraint

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

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

If restraint is used, staff must reasonably believe the person lacks capacity to consent to the act in question, that it needs to be done in their best interests and that restraint is necessary to protect the person from harm. It must also be a proportionate or reasonable response to the likelihood of the person suffering harm and the seriousness of that harm. Restraint can include physical restraint, restricting the person's freedom of movement and verbal warnings, but cannot extend to depriving someone of their liberty (the difference between restraint and deprivation of liberty is discussed in Part 7.2 below).

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

BOX 23

Example

Ida, who has severe dementia, walks out of the day centre she attends and is found by staff near a busy road. The staff members who find her hold her by the arm on either side and walk her back to the day centre. This incident is recorded in her file and it is noted that this approach may need to be considered again in similar circumstances in the future. It is not possible to make such decisions in advance because the MCA says that decisions can only be made in the best interests of somebody lacking capacity at the time that the decision needs to be made.
Section 5 of the MCA, which provides protection from liability in certain circumstances as discussed above, will not protect staff from liability for any action they take that conflicts with a decision made by someone acting under a Lasting Power of Attorney or a deputy appointed by the Court of Protection, whose authority extends to such decisions. Nor does it protect staff against negligent acts. (For more information, see Chapter 6 of the Code of Practice).

7.2 The Bournewood Case

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

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

The European Court of Human Rights determined that:

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

The Court found that:

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

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

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

You might want to think about who you should contact if you are worried about a Bournewood-type case. You will need to discuss this with a senior person in your organisation, such as your supervisor or a senior manager. You should record your concerns and what actions you have taken.

At this point, you have:

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

(Code of Practice, Chapter 16)

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

When releasing information, the following questions must be considered:

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

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

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

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

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

Attorneys with a Lasting Power of Attorney (LPA) are entitled to as much information as if they were the person lacking capacity. Court of Protection visitors have a right of access to records and independent mental capacity advocates have a right of access to that part of a person’s records relevant to the decision in question. Court of Protection deputies may have access to a person’s records if the Court gives them that power.
BOX 24

The person who is asked or intends to disclose information should ask:

- Is the disclosure lawful?
- Is the disclosure justified, having balanced the best interests of the person lacking capacity and/or the public interest against the rights to privacy of the person lacking capacity?

The following questions should help to answer the last two points:

- Do I (or does my organisation) have the information requested?
- Am I satisfied that the person concerned lacks capacity to consent to the information being disclosed?
- Does the person requesting the information have any formal authority to act on behalf of the person lacking capacity, e.g. an LPA?
- Am I satisfied that the person making the request is acting in the best interests of the person who lacks the capacity?
- Am I satisfied that they need the information in order to act properly?
- Am I satisfied that they will respect any confidentiality?
- Am I satisfied that they will keep the information for no longer than necessary?
- Should I seek a formal undertaking as to these matters?
**BOX 25**  

**Example**

Shirley is a single woman, 36 years of age, with a diagnosis of bipolar disorder that has resulted in periods of mania leading to a number of hospital admissions. When she was well, Shirley made arrangements for LPA to be given to her sister, Janice. She made two separate LPAs that covered decisions relating both to hospital treatment and to financial matters when Shirley was incapacitated by her mental disorder. On this occasion, Shirley has been admitted to hospital suffering from very severe depression. On visiting her sister, Janice is concerned about Shirley’s dishevelled appearance, apparent weight loss and dry, cracked lips. Janice asked to see Shirley’s care plan and file. Ward staff are not sure what to do regarding confidentiality.

**What should the ward staff do?**

Janice is a personal welfare attorney. With the LPAs she is, legally, her sister’s agent and the LPAs give her authority to look after her sister’s welfare. She needs to see specific personal data in order to ensure proper care is provided to Shirley, and the ward staff should give it to her and talk to her about her sister. With the power under the LPA, the Data Protection Act 1998 requires the ward manager to provide access to personal data held on Shirley in this respect. Janice should immediately contact the Patient Advice and Liaison Service (PALS) if the ward manager continues to refuse access, and should ask the ward manager to contact the hospital management team for confirmation of the legal position if she is still unsure.

At this point, you have:

- identified the questions to ask when sharing information
- noted that attorneys with LPAs are entitled to information.
9 Safeguards and complaints

9.1 The Court of Protection
(Mental Capacity Act, Part 2; Code of Practice, Chapter 8)

The Court of Protection is a specialist court with powers to deal with matters affecting adults who may lack capacity to make particular decisions. The Court is able to hear cases at a number of locations in England and Wales. It covers all areas of decision making under the Mental Capacity Act 2005 (MCA) and can determine whether a person has capacity in relation to a particular decision, whether a proposed action would be lawful, whether a particular act or decision is in a person’s best interests and the meaning or effect of a Lasting Power of Attorney (LPA) in disputed cases.

The Court of Protection plans to be an accessible regional court. It aims to be informal and quick. It takes over the duties of the former Court of Protection and matters regarding healthcare and personal welfare that were previously dealt with by the High Court. The Court charges a fee for applications – information on fees and forms are available on the Public Guardianship Office website at: www.guardianship.gov.uk or www.publicguardian.gov.uk (from October 2007).

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

Either the Court of Protection or the Family Court may deal with health and welfare decisions concerning 16- and 17-year-olds who lack capacity to make particular decisions (see Part 10.2 of these materials).

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

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

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

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

**BOX 26**

**Example**

Nilu asked her son Ram to manage her financial affairs but did not make this arrangement formal in any way. Nilu now has advanced dementia and depression and has moved in with Ram and his family. The rest of the family is concerned that Ram is proposing to sell Nilu’s house and use the proceeds to carry out various alterations to his own home, arguing that these will help him take better care of his mother. The other family members say the installation of an indoor swimming pool to Ram’s home is unlikely to benefit Nilu. Relationships between Ram and the rest of the family are becoming increasingly angry, making it hard for them to reach agreement on other decisions that need to be taken about Nilu’s care. The home care service has told Nilu’s daughter that it is owed a large sum of money.

The family, possibly Nilu’s daughter, could ask the Court of Protection to resolve these disputes in Nilu’s best interests. The Court could decide to appoint a deputy.

**9.3 Resolving disputes**

The Court of Protection will only act in disputes when alternative solutions to resolving them have been considered and tried. This should happen before any application to the Court of Protection. The Court will consider if appropriate alternatives have been pursued when an application is made. The Court determines which applications it will accept.
BOX 27

Resolving disputes informally

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

BOX 28

Example

Margot, a young woman with a diagnosis of schizophrenia, lives at home with her parents. As part of her recovery programme, she has discussed with the care team moving into an expensive group home. Margot is particularly friendly with one of the male residents of the group home. However, Margot’s mother objects to this plan as she thinks that Margot is not responsible enough to cope with the regime of the home and is concerned about Margot’s relationship with the man. Margot has access to substantial savings that she inherited from her grandmother that would be needed to pay for the place in the home, as the NHS or Social Services will not fund it. Margot’s mother is opposed to this use of her savings. The care team supports this opportunity for Margot’s personal development.

However, after discussing the situation with Margot’s mother, the team decides that a resolution can be reached through negotiation, which would benefit Margot. Following a number of meetings with Margot, her mother and the other residents in the group home, it is agreed that Margot’s ability to participate in the recovery programme will be assessed by a number of short stays in the group home, which will be monitored by the care team.
9.4 Raising concerns and complaints

The Court of Protection only deals with complaints when all other avenues have been tried. So if a care worker, for example, wants to make a complaint about the way in which her client’s attorney is mistreating her client, then she can contact the Office of the Public Guardian, she can use whistleblowing procedures or contact the local adult protection service (via the local authority), or the Commission for Social Care Inspection or the Social Care Inspectorate in Wales. Other sources of help include telephone advice from the Action on Elder Abuse helpline or Witness: www.popan.org.uk/

9.5 The Public Guardian

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

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

Isabel said:

“I think the new Public Guardian opportunity for complaints is a good one. But I fear it will remain hidden from the people who need to know about it, as have many of the complaints systems in the past. And I think that in order to make that part of the Act meaningful, a new think, a rethink will have to take place as to how we inform people at the grass roots, as to how they can access those processes which they find intimidating.”
9.6 **New criminal offences of ill-treatment or wilful neglect**  
* (Mental Capacity Act, Section 44; Code of Practice, Chapter 14)  

The MCA creates new criminal offences of ill-treatment or wilful neglect, which may apply to the following:  
- people who have the care of a person who lacks capacity  
- an attorney acting under an LPA or EPA  
- a deputy appointed by the Court.

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

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

**BOX 29**  
**Example**  
Mabel is 90 and has dementia. She lives with her son, Michael, who is her main carer and welfare attorney under an LPA. A community nurse regularly visits Mabel to assist with dressings. She is concerned that Mabel is displaying bruises and other injuries. She suspects that Michael is assaulting Mabel when he is drunk.

The nurse alerts her manager and they contact the police and the local adult protection service. A joint social services and police investigation is carried out and Michael is charged with the ill-treatment of Mabel. The local authority decides to instruct an independent mental capacity advocate to represent Mabel, as, although she has a relative, he is involved in the charges. In addition, the Court, in conjunction with the Public Guardian, also takes steps to terminate the LPA. Social services (adult services) make alternative care arrangements for Mabel.
At this point, you have:

- learnt that the Court of Protection has a role in resolving disputes, but only after alternative solutions have failed
- noted the role of the Office of the Public Guardian
- identified alternative solutions to dispute resolution
- been alerted to the new criminal offences of ill-treatment and wilful neglect.
10 Children and young people

10.1 Young people under the age of 16

The Mental Capacity Act 2005 (MCA) does not usually apply to children younger than 16 who do not have capacity. Generally, people with parental responsibility for such children can make decisions on their behalf under common law. However, the Court of Protection has powers to make decisions about the property and affairs of a person who is under 16 and lacks capacity within the meaning of the MCA (see Part 2.4 of these materials) if it is likely that the person will still lack capacity to make these types of decision when they are 18.

BOX 30

Example

Emma, who is 16, has inherited a large amount of money. She has a brain injury arising from an accident and this means she is currently not able to make significant decisions. Emma is unlikely to recover sufficiently to have the capacity to be able to make any financial decisions for herself when she reaches 18. The Court of Protection makes an order appointing Emma’s mother as deputy to manage her financial affairs.

10.2 Young people aged 16 and 17

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

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

Another example would be where the Court of Protection is asked to make a best interests decision where there is a dispute between those with parental responsibility for a young person and those treating or caring for the young person and the dispute cannot be resolved in any other way.
Under the MCA, only people who have reached the age of 18 can make Lasting Powers of Attorney (LPAs) and advance decisions. While 16- and 17-year-olds who have capacity may give or refuse consent to treatment at the time it is offered, they cannot make advance decisions under the MCA. However, any views or preferences they express when they have capacity should be considered when making a best interests decision.

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

10.3 Young carers

Staff may also need to involve young people who are caring for a parent with mental health needs in assessment and best interests decisions. A useful website to consult about young carers’ rights and needs is: www.youngminds.org.uk/youngcarers

A website aimed at young carers themselves is: www.getconnected.org.uk

At this point, you have:

• confirmed that the MCA generally only applies to people aged 16 and over

• discovered that the Court of Protection can be involved in decisions for someone under 16 if they are likely to continue to lack capacity to make those decisions when they reach 18

• learnt that only people of 18 and over can make LPAs and advance decisions under the MCA

• clarified that a 16- or 17-year-old who lacks capacity can be treated under the MCA.
11 Research

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

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

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

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

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

NB: There are separate rules for clinical trials.
Example

Mrs Singh has a diagnosis of Alzheimer’s disease and is confused and often distressed. She attends a day hospital. Paul, a psychology assistant, is undertaking a study to investigate the therapeutic effect of music in dementia care as part of his university course. Paul has received approval to carry out the study from the relevant research ethics committee.

Paul establishes that Mrs Singh does not have capacity to decide for herself whether to take part in his study. Paul tells her son about his study and asks him whether he thinks his mother would want to take part if she could decide for herself. Her son thinks she would have wanted to be included but when approached, Mrs Singh becomes agitated. Paul is told by Mrs Singh’s key worker that Mrs Singh’s behaviour can be interpreted as an objection and he cannot include her in his research.

At this point, you have:

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

Communicating with service users and patients

In commenting on the skills needed by staff working with the Mental Capacity Act 2005 (MCA), service users and carers emphasised the importance of taking time over communicating with people who may lack capacity and being prepared to communicate in different ways.

Eileen reflected:

“I think they need to be skilled, consistent and reliable in their own areas of expertise, but probably more importantly they need to be kind and they need to be able to listen or pick up non-verbal signals and to recognise the importance of a person’s life experience. I’m thinking mostly about older people and what’s important to that person. They (staff) need to be able to provide a secure but stimulating environment; to be able to focus on what they (service users) can do, not what they can’t do; to value or at least accept the person’s views and values, not impose their own.”

Users and carers hoped that the MCA would encourage staff to acknowledge their dignity and rights to make choices. They emphasised that all service users want to be treated with warmth and respect.

Frances said:

“I benefit from a practitioner having a warm approach with me. A warm approach goes a long way to convey the practitioner’s interest in you as a person, rather than as just another client. A warm approach can also help to build trust and instil confidence in the practitioner’s good intent.”

Frances and other service users and carers have identified the need for patience. It is important that practitioners make every effort to obtain the service user’s views and do not just do things because it is quicker and more convenient for them. Frances also pointed out that it is important to “see” the individual:

“The individual’s personality and true nature is often overshadowed by the illness. With patience the practitioner could hopefully get to ‘see’ the person behind the illness, and work with them rather than the ill mindset.”

Ade reminded us:

“This Act is saying we must not prejudge people, however bizarre their behaviour may seem to others.”
Exercise:
Think about how you might make changes to your practice. Ensure your work is guided by the MCA. Discuss with your colleagues how you might start to change routine day-to-day aspects of your work and the approach of the team or service to which you belong.

In conclusion, you have:
- learnt the key elements of the MCA
- reflected on the implications for your own practice
- listened to hopes and views of users and carers about the way in which the MCA will improve practice.
### Appendix 1 – Distinguishing between nearest relatives, lasting powers of attorney, independent mental capacity advocates and deputies

<table>
<thead>
<tr>
<th>Nearest relative as defined by the MHA</th>
<th>Lasting power of attorney (LPA)</th>
<th>Independent mental capacity advocate (IMCA)</th>
<th>Court-appointed deputy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not chosen by service user and is one person only; nearest relative may or may not hold the LPA (if there is one); often the person’s main carer</td>
<td>Chosen by service user and may be more than one person; LPA may or may not be held by the nearest relative</td>
<td>For people without family or friends or contacts outside of the care team</td>
<td>For people without LPA who lack capacity and where major decisions have to be made</td>
</tr>
<tr>
<td>Functions can be delegated</td>
<td>Role cannot be delegated</td>
<td>Instructed by the local authority or NHS body</td>
<td>Appointed by the Court of Protection</td>
</tr>
<tr>
<td>On limited grounds, nearest relative may be displaced (and an acting nearest relative appointed) by the County Court</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No automatic right to personal information</td>
<td>Has right to access personal information needed to carry out the role</td>
<td>Has right to access personal information needed to carry out the role</td>
<td>Has right to access personal information needed to carry out the role</td>
</tr>
<tr>
<td>Has powers to:</td>
<td>May be involved in decisions about:</td>
<td>Consult widely when major decisions are needed about:</td>
<td>Is appointed by the Court for specific decisions, such as medical treatment and financial matters</td>
</tr>
<tr>
<td>- seek assessment by an ASW with a view to an application for detention</td>
<td>- personal welfare including health care</td>
<td>- serious medical treatment</td>
<td>Is a decision maker</td>
</tr>
<tr>
<td>- object to admission for treatment (Section 3 guardianship)</td>
<td>- property and affairs</td>
<td>- transfer of accommodation</td>
<td></td>
</tr>
<tr>
<td>- make application for admission</td>
<td></td>
<td>- reviews of accommodation</td>
<td></td>
</tr>
<tr>
<td>- order discharge (subject to certain limitations)</td>
<td></td>
<td>- abuse cases, including when family of friends implicated</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Is not a decision maker</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 2 – Quick reference guide to key provisions in the Mental Health Act

The Mental Health Act 1983 (MHA) provides, in particular, a framework for the compulsory detention and treatment in hospital of people suffering from mental disorders, where that is warranted. It provides a range of procedural and other safeguards. It is supported by a Code of Practice. At the time of writing there is a Mental Health Bill before Parliament which will amend some parts of the MHA.

The MHA refers to service users who have, or appear to have, a mental disorder as patients. Informal patients (sometimes called ‘voluntary patients’) are free to leave hospital, unless at the time they want to leave they represent an immediate serious risk to themselves or others. Detained patients cannot do so unless their responsible medical officer (RMO), a Mental Health Review Tribunal (MHRT) or Managers’ Hearing, or nearest relative (NR) agrees. (An NR’s decision to discharge may be blocked by the RMO if the patient would act dangerously if discharged.) Detained patients may be granted periods of leave by their RMO before they are discharged from their detention.

A decision to detain a person in hospital (under civil sections) is usually made by two doctors, one of whom is authorised under Section 12 of the MHA (in most cases a psychiatrist), another doctor (who might be the patient’s GP) and an Approved Social Worker (ASW) who has received training in mental health and mental health law. The term ‘sectioned’ is often used when a person is detained because he or she is placed under a particular section of the MHA – but it is a term best avoided as it is considered offensive by many service users. An assessment to decide whether an application should be made for a patient to be detained under the MHA can take place in hospital or in the community.
<table>
<thead>
<tr>
<th>Section</th>
<th>What it is for</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 131</td>
<td>Informal hospital admission for treatment. Patient is free to leave.</td>
<td>No specified time</td>
</tr>
</tbody>
</table>
| Section 2 | Assessment in hospital.                                                        | Lasts up to 28 days unless discharged by the RMO, MHRT, hospital managers or NR  
This section cannot be renewed |
| Section 4 | Assessment in hospital – emergency admission. Only one doctor makes the recommendation. | Lasts up to 72 hours unless discharged by any of the above. Can be converted to Section 2 if a second doctor recommends |
| Section 3 | Treatment in hospital.                                                         | Lasts up to 6 months can be renewed for a further 6 months and thereafter at yearly intervals  
Can be discharged by the RMO, MHRT, hospital managers or NR |
<p>| Section 5(2) | Allows a hospital doctor to stop a patient leaving hospital to give time for a full assessment to see whether the patient should be formally detained under the Act. | Lasts up to 72 hours |
| Section 5(4) | Allows certain nurses to stop a mental health inpatient leaving hospital where there is a need for them to be detained pending an assessment under section 5(2). | Lasts up to 6 hours |
| Section 135 | Allows an ASW to obtain a warrant for the police to enter the home of a person thought to be suffering from mental disorder in certain circumstances and take them to a hospital or other place of safety. Gives time for further assessment. | Lasts up to 72 hours |
| Section 136 | Allows the police to take a person believed to be suffering from mental disorder and found in a public place to a hospital or other place of safety. Gives time for medical and approved social worker assessment. | Lasts up to 72 hours |</p>
<table>
<thead>
<tr>
<th>Section</th>
<th>What it is for</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 17</td>
<td>Leave from hospital for detained patients. Can be extended to allow patients detained under a treatment section to settle in the community.</td>
<td>No specified time. Case for continuing necessity for liability for detention in hospital for treatment must be made</td>
</tr>
<tr>
<td>Section 7</td>
<td>Guardianship – a community provision. Allows authorities to stipulate: • where the patient should live • where they should go for treatment and other therapeutic activities • access is given to named individuals.</td>
<td>Lasts up to 6 months; can be renewed for a further 6 months and thereafter at yearly intervals Can be discharged by the RMO, social services MHRT or NR</td>
</tr>
<tr>
<td>Section 25 A–J</td>
<td>‘Supervised discharge’ or ‘medical guardianship’ for patients where serious risks to their health, safety or protection of others are involved. Like guardianship (above) but also allows authorities to convey a patient to a place for treatment. Appointment of Community RMO and supervisor.</td>
<td>Lasts up to 6 months; can be renewed for a further 6 months and thereafter at yearly intervals Can be discharged by the RMO or MHRT</td>
</tr>
</tbody>
</table>
## Part 3 – Mentally disordered offenders

<table>
<thead>
<tr>
<th>Section</th>
<th>What it is for</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 35</td>
<td>Court powers to remand prisoner to hospital for psychiatric report.</td>
<td>Lasts up to 28 days; can be remanded for a further 28 days but not for more than 12 weeks in all</td>
</tr>
<tr>
<td>Section 36</td>
<td>Court powers to remand for treatment.</td>
<td>Lasts up to 28 days; can be remanded for a further 28 days but not for more than 12 weeks in all</td>
</tr>
<tr>
<td>Section 37</td>
<td>Court powers to send an offender to hospital for treatment (or to place under social services guardianship (rare)).</td>
<td>Lasts up to 6 months; can be renewed for a further 6 months and thereafter at yearly intervals Can be discharged by the RMO, MHRT or managers (guardianship – social services)</td>
</tr>
<tr>
<td>Section 37/41</td>
<td>Court powers to make a restriction order when sending an offender to hospital for treatment, in order to protect public from risk of serious harm. Places various restrictions on patient and permits conditional discharge (under which patient remains liable to recall to hospital).</td>
<td>May be without limit of time Can be discharged by Home Secretary or MHRT</td>
</tr>
<tr>
<td>Sections 47 and 48</td>
<td>Transfer of prisoners by Home Secretary to hospital for treatment.</td>
<td>Can be discharged by RMO, MHRT, managers (s47)</td>
</tr>
<tr>
<td>Section 49</td>
<td>Places restrictions on discharge from Section 47 or 48.</td>
<td>Home Secretary and MHRT (but patient may be returned to prison to complete sentence)</td>
</tr>
</tbody>
</table>

### Capacity and consent to treatment under the Mental Health Act

Under Section 58 of the MHA, if after three months the RMO wishes to continue with the administration of medication for the treatment of the mental disorder, they must first seek the valid consent of the service user. To do this the RMO needs to be sure the service user has understood:

- the nature of the treatment
- its purpose
- the likely effects of the treatment.
If the doctor is not satisfied that the service user has capacity to give valid consent, or the service user disagrees with the treatment, then a second opinion appointed doctor (SOAD) must be requested from the Mental Act Commission to verify the treatment plan. Only if the SOAD agrees can the treatment proceed.

There are different rules for the administration of electro-convulsive therapy, treatments in an emergency and psychosurgery.

**Valid consent** can be defined as the voluntary and continuing permission of the patient to receive a particular treatment, based on an adequate 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.
Glossary

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

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

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

**Capacity** – the ability to make a decision.

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

**Court of Protection** – where there is a dispute or challenge to a decision under the Mental Capacity Act 2005, this Court decides on such matters as whether a person has capacity in relation to a particular decision, whether a proposed act would be lawful, and the meaning or effect of a Lasting Power of Attorney or Enduring Power of Attorney.

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

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

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

**Enduring Power of Attorney (EPA)** – a power of attorney to deal with property and financial affairs established by previous legislation. No new EPAs can be made after the Mental Capacity Act 2005 is implemented, but existing EPAs continue to be valid.
Independent mental capacity advocate (IMCA) – an advocate who has to be instructed when a person who lacks capacity to make specific decisions has no one else who can speak for them. They do not make decisions for people who lack capacity, but support and represent them and ensure that major decisions regarding people who lack capacity are made appropriately and in accordance with the Mental Capacity Act 2005.

Lasting Power of Attorney (LPA) – a power under the Mental Capacity Act 2005 which allows an individual to appoint another person to act on their behalf in relation to certain decisions regarding their financial, welfare and healthcare matters.

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

Further information is available in the training sets that accompany this material. Links to more information and reference to the Mental Capacity Act 2005 (MCA) and Code of Practice are included in the text where relevant. The following list includes other articles or books that may be of interest.

Department for Constitutional Affairs

Range of material including the statutes and an easy read summary of the MCA available on the website:
www.dca.gov.uk/legal-policy/mental-capacity

Department of Health

website:
www.dh.gov.uk/mentalcapacityact

Welsh Assembly Government

Guidance issued for Wales available on website:
http://new.wales.gov.uk/topics/health/nhswnh/service/mental_health_services/mental_capacity_act/?lang=en


Certificate of Completed Learning Hours

Mental Capacity Act 2005
Mental Health Training Set

Continuing Professional Development (five hours)

I certify that I, ......................................................

have completed this Mental Health Training Set