Bury Safeguarding Partnership

Bury Safeguarding Adults Board

Mental Capacity Act and Deprivation of Liberty Safeguarding Policy and Procedure for Staff

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Contents

Please note that this guidance does not supersede any individual organisational guidance on these matters.

1. Introduction

1.1 The Mental Capacity Act (MCA) 2005 is designed to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment. It applies to people aged 16 and over. It covers decisions about day-to-day things like what to wear or what to buy for the weekly shop, or serious life-changing decisions like whether to move into a care home or have major surgery.

1.2 The MCA has five principles, which underpin its fundamental concepts and govern its implementation. The five key principles are:

- *Assume capacity unless it is proved otherwise* – every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise
- *Give all appropriate help before concluding someone cannot make their own decisions* – everyone should be encouraged and enabled to make their own decisions, or to participate as fully as possible in decision-making, by being given the help and support they need to make and express a choice
- Accept the right to make what might be seen as eccentric or unwise decisions
- *Always act in the best interests of people without capacity* - decisions made on behalf of people without capacity should be made in their best interests, giving weight to the decision being what they themselves would have wanted; and
- *Decisions made should be the least restrictive of their basic rights and freedoms*.

1.3 The deprivation of liberty safeguards were introduced to provide a legal framework around the deprivation of liberty. Specifically, they were introduced to prevent breaches of the European Convention on Human Rights (ECHR).

1.4 In some cases, people lack the capacity to consent to particular treatment or care that is recognised by others as being in their best interests, or which will protect them from harm. Where this care might involve depriving vulnerable people of their liberty in either a hospital or a care home, extra safeguards have been introduced, in law, to protect their rights and ensure that the care or treatment they receive is in their best interests.

1.5 The deprivation of liberty safeguards provide legal protection for those vulnerable people who are, or may become, deprived of their liberty within the meaning of Article 5 of the ECHR in a hospital or care home, whether placed under public or private arrangements. They do not apply to people detained under the Mental Health Act 1983.

2. Purpose

2.1 The purpose of this policy is to inform staff about the arrangements for working with service users over the age of 16 who lack the mental capacity to make decisions about their care and treatment.

2.2 It will set out the procedures for staff to follow in assessing capacity and making best interest decisions.

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3. Scope

3.1 Staff who are involved in providing care, support or treatment to a person who lacks capacity are legally obliged to implement the MCA and Code of Practice.

3.2 This document will set out the policy context and procedures for multi-agency professionals to follow.

4. The Code of Practice

4.1 Despite the existence of this policy and procedure you are legally required to have regard to the most recent Code of Practice in relation to MCA.

If you have to go to Court or Tribunal for any criminal or civil proceedings and it appears that you have not regarded, or have failed to comply with the code this will be taken into account in any subsequent determination that is made.

Click here to access the Code of Practice for the Mental Capacity Act 2005.

Click here to access the Code of Practice for the Deprivation of Liberty Safeguards

5. Roles and Responsibilities of Staff Working with the Mental Capacity Act

5.1 Health and Social Care Staff

5.1.1 The Mental Capacity Act (2005) identifies the need for all practitioners to carry out decision and time specific assessments of mental capacity where there are doubts about a person's ability to make that decision. The kinds of decisions which are covered by the MCA 2005 range from day-to-day decisions to significant decisions.

5.1.2 More serious decisions have greater consequences for the person who, it is thought, may lack capacity, and justify a more formal assessment of capacity. The latter includes decisions relating to providing healthcare or treatment include providing nursing and social care, major financial decision, carrying out diagnostic examinations and tests, providing professional medical treatment, giving medication, providing emergency 5 care, carrying out other necessary medical procedures and therapies and arranging to refer someone to hospital for an assessment or for treatment.

5.1.3 Some decisions can never be made in a person's Best Interests e.g. marriage, divorce, voting, sexual relationships.

5.2 Ambulance Service

5.2.1 North West Ambulance Service NHS Trust (NWAS) provides ambulance services to the North West of England including Greater Manchester.

5.2.2 There are two significant MCA interfaces with NWAS:

- A*cting in the Best Interests of a patient who lacks mental capacity* - Clinicians should use the two stage MCA test of capacity to make an assessment of the person's mental capacity and a Best Interests decision should be made. If a decision is made to convey in the persons' Best Interests, clinicians should try to persuade the patient to cooperate with them. If the patient is resisting transfer to a local hospital, clinicians should use necessary and proportionate restraint. If the patient continues to actively resist and there is a significant risk of injury to either the patient or Clinicians, they should request the assistance of Greater Manchester Police. In both incidences the form 'Conveyance of Patient Lacking Capacity to Hospital/Care Home' (MCA18), should be completed. If a decision is made not to convey the decision should be appropriately documented. Clinicians should also consider whether a 'Vulnerable Adults' referral is indicated in this incidence.

- Acting with respect *to an Advance Decision that has been made by a patient* - The ambulance service has the capacity to 'flag' specific instructions, as a 'clinical alert' to a patients' address which will be relayed to crews responding to an emergency call. Best Interests 'allow a natural death' (Do Not Attempt Cardio-Pulmonary Resuscitation) decisions are generated by health professionals rather than patients but must also be signed by the patients GP or appropriate doctor. All advance care documents must also be retained within the client's home and be easily accessible in an emergency. Health and social care staff should inform the NWAS Medical Director of Advance Decisions to allow a natural death in order that a clinical alert can be instigated.

5.3 Police

5.3.1 Although the Mental Capacity Act is primarily aimed at health and social care professionals and carers when making decisions about a person's welfare, it will in some circumstances be applicable to police officers where a person whom it is reasonably believed lacks capacity appears to be in need of emergency circumstances where death or serious harm may occur to someone who refuses treatment or help (the MCA also covers temporary incapacity due to injury (concussion following a head injury for example), substance misuse and mental ill health. In these cases officers will usually need to make immediate decisions while awaiting further assessment by a health or social care professional.

5.3.2 The MCA applies in both public and private. The police may be able to gain entry to private premises through the power enacted under S.17 of the Police and Criminal Evidence Act (PACE) in order of saving life or limb or preventing serious damage to property where there is reasonable belief. The circumstances may then be such that subsequently the use of the Mental Capacity Act is an appropriate solution to deal with the incident.

5.3.3 It should be noted however that in the case of *R (Sessay) v (1) South London and Maudsley NHS Foundation Trust and (2) Commissioner of Police of the Metropolis*

[2012] 2 WLR 1071 it was made clear that the Mental Capacity Act cannot be used to remove apparently mentally disordered persons to a Place of Safety for the purposes set out in sections 135 and 136 of the MHA. The Police cannot remove a person when in a private premises for the purposes set out in section 135 and 136 of the MHA. However a Police Officer can remove a person who is not in a private premises to a place of safety under S 136 if it appears to the officer that the person is suffering from a mental disorder and to be in immediate need of care or control. The officer must think that it is in the best interest of the person or the protection of others to do so. An officer can also keep that person at the place of safety or remove them to another place of safety if necessary.

5.3.4 It may, in appropriate circumstances, be possible to rely on s.5 and s.6 of the Mental Capacity Act to provide protection from liability in civil and/or criminal proceedings for necessary acts done in the Best Interests of a person lacking capacity. This protection only applies where the officers have taken the following steps:

1. Take reasonable steps to establish whether the person lacks capacity in relation to the decision in question.

2. Reasonably believe that:

- the person lacks capacity in relation to the matter; and
- it is in the person's Best Interests for it to be done.

The MCA Code of Practice paragraph 6.5 sets out various actions that might be covered by s.5, including taking someone to hospital for assessment or treatment and providing care in an emergency.

5.3.5 Where restraint is carried out, officers must reasonably believe it is necessary to prevent harm to the person and the restraint must be a proportionate response to the likelihood of harm and the seriousness of that harm (s.6 (2) and (3)). Restraint occurs where there is force applied or threatened force to ensure the action which the person resists or where there is restriction of the person's liberty of movement, whether or not s/he resists. Note that the Mental Capacity Act does not permit use of restraint to be used where the threat of harm or damage is towards other persons or property, in these cases Police should rely upon their powers from PACE where a criminal offence has been committed.

5.3.6 If officers encounter a person whom they reasonably believe to lack capacity in relation to the specific decision, they should consider taking action to safeguard the person's Best Interests, having regard to how that purpose can be achieved in a way that places the least restrictions on the person's rights and freedom of action. Some people will experience **fluctuating capacity** which can affect their ability to understand information and make decisions within a period of time.

5.3.7 Where police are the only service on scene it may be necessary to make an assessment of capacity and act accordingly before other services arrive due to the seriousness or urgency of the situation. If the Mental Capacity Act is used, officers should ensure they record the steps they took to establish the person lacked capacity. When a doctor, member of the ambulance service or other professional

arrives on the scene, police should defer to their expertise and provide support as appropriate.

5.3.8 Although it is not possible to be prescriptive in advance, because each case has to be assessed on its merits, officers may wish to consider carefully whether in any particular case it would be practicable to avoid transporting a person in a police van and to use an ambulance instead. It is GMP policy to request an ambulance however if one is not readily available then it would be necessary for police to transport, and whether mechanical forms of restraint are absolutely necessary. If a person is restrained in handcuffs and leg restraints and transported in a police van, for example, there is likely to be a deprivation of liberty. For the police to use powers under Section 5 of the Mental Capacity Act, there must be an emergency situation. The police also need make reasonable adjustments (if there is time in an emergency situation) to their application of usual control and restraint due to the persons incapacity.

5.3.9 The police may also be involved in decisions to prosecute under Section 44 of the Mental Capacity Act. The Act introduces criminal offences: ill-treatment and wilful neglect of a person who lacks capacity to make relevant decisions.

5.4 Voluntary Sector Providers

5.4.1 It is expected that all partners and voluntary sector providers develop their own organisational Mental Capacity Act operational procedures to apply when concerns about a person's decision making is apparent.

5.4.2 In the first instance, if concerns are identified, providers are advised to discuss this with the person and advise them to contact the relevant professional (e.g. GP, adult social care, health provider) or, with consent, do this on their behalf, however, if there is concern regarding life or limb or decisions that could affect their welfare, their safety or the health of others, then actions should be taken regardless of the persons consent.

6. Assessing Capacity

6.1 The Test of Capacity

The MCA sets out a single clear test for assessing whether a person lacks '*capacity to take a particular decision at a particular time'*. It is a '*decision-specific'* test. No one can simply be labelled 'incapable' as a result of a particular medical condition or diagnosis. Reference should be made to chapter 4 of the code of practice, which looks at how the Act defines a person's capacity to make a decision and how capacity should be assessed.

6.2 **Defining a Lack of Capacity**

6.2.1 The law gives a specific definition of what it means to lack capacity for the purposes of the MCA 2005. It is a legal test, and not a medical test as described in s.2(1) MCA 2005: '*a person lacks capacity in relation to a matter if at the material time he is unable to make a decision himself in relation to the matter because of an impairment of, or disturbance in the functioning of the mind or the brain'*.

6.2.2 It does not matter whether the impairment or disturbance is permanent or temporary.

6.2.3 A lack of capacity cannot be established merely by reference to:

- a person's age or appearance, or
- a condition or an aspect of their behaviour which might lead others to make unjustified assumptions about their capacity

6.2.4 Any question whether a person lacks capacity must be decided on the balance of probabilities and the 'burden of proof' is for the professional undertaking the assessment to identify that a person has or has not got capacity regarding specific decision making.

6.2.5 To apply the capacity test, it can be broken down into three questions:

- Is the person able to make a decision? If they cannot:
- Is there an impairment or disturbance in the functioning of the person's mind or brain? If so,
- Is the person's inability to make the decision because of the identified impairment or disturbance?

The ordering of the first and second questions are opposite to what is set out in the Code of Practice but is considered best practice – see case law PC and NC v City of York Council (2013).

6.3 **Ability to Make Decisions (The Functional Test)**

6.3.1 A person is unable to make a decision if they do not meet any one of the following criteria:

1. Understand information relevant to the decision

    - The person must be able to understand the nature of the decision and the consequences. The understanding does not need to be in depth, a broad understanding is acceptable under the MCA 2005.

    - The information should include possible options and what happens if the decision is not made.

    - All possible help must be given to the person to understand the information, including using simple language and visual aids, if needed.

    - The assessor should undertake the assessment in the best environment for the person and at the best time of day for them.

2. Retain that information

    - The information only needs to be retained for long enough to make the decision in question. There is no set time limit for how long this is.

    - The person only needs to have capacity at the time the decision needs to be made. It might be necessary to repeat the discussion again at another time before the action is taken to demonstrate that the person's decision is the same.

    - It is important to help the person retain the information, use of notes or recording the decision are septs that could be taken.

3. Use or weigh that information as part of the process of making the decision

    - The person should be able to demonstrate that they understand the consequences of the decision.

    - This might mean giving them time to think about it and to weigh the advantages and disadvantages.

    - It might be necessary to involve another person to help in the weighing up process such as an advocate, carer, friend or family member.

4. Communicate their decision (whether by talking, using sign language or any other means)

    - The assessor should ensure that the person's capacity is not misjudged because they have difficulty understanding them.

6.3.2 Assessors are required to have due consideration to other parties involved in an individual's life and decision making and best practice denotes that parents, carers, providers should be consulted as to their knowledge of an individual's known wishes. This is to ensure that the individuals stated wishes prior to incapacity are recorded.

6.3.3 Capacity should be presumed unless there is clear evidence to the contrary. In the case of receivers & deputies, the application requires a certificate to be completed by the GP or specialist to confirm mental incapacity before they can be appointed.

6.4 Factors Which May Affect Capacity

6.4.1 A person's mental capacity can vary or be temporarily impaired due to mood or depression and drug or alcohol intoxication. Alcohol Change UK – How to use legal powers to safeguard highly vulnerable dependant drinkers in England and Wales. In these circumstances, it may be possible to put off a decision until such time as the person has regained capacity.

6.4.2 A person's mental capacity may also vary or be temporarily impaired due to an underlying physical disorder, known as delirium or *'acute confusional state'* which is a common clinical syndrome characterised by disturbed consciousness, cognitive function, or perception, which has an acute onset and fluctuating course. It usually develops over 1–2 days.

6.4.3 A person may have the capacity to make some decisions but not others. We must weigh up a person's capacity against the specific decision that needs to be made. For example, a person who cannot understand the financial issues around entering long term care might still have the capacity to make a choice about whether they want to go into long term care at all and, if so, which home.

6.4.4 *Information* - Make sure that any information relevant to the decision is provided in a format that the person can understand.

6.4.5 *Pressure/Coercion* - Carers or family members may sometimes exert undue pressure on the person, when actually the person is capable of making their own decisions or where expert help maybe required to help them do so. The Domestic Abuse Act 2021 introduced a statutory definition of Domestic Abuse which also includes emotional abuse, coercive and controlling behaviour and economic abuse. https://www.lawsociety.org.uk/topics/family-and-children/domestic-abuse-act-2021 If the person has care and support needs as defined in the Care Act 2014 this may also constitute safeguarding, and a safeguarding concern should be raised through the appropriate channels.

6.4.6 *Disguised compliance* - Involves parents, carers and users of services giving the appearance of co-operating or being pleasant with professionals to avoid raising suspicions and allay concerns.

In adults it could be a sign of a cognitive impairment or issues with their executive functioning or other illness (delirium caused by urinary tract infection) that may affect their capacity to carry out certain tasks. However, they want to hide this from professionals and their family, as they don't want to show their loss of independence.

It can also be an indication of an individual experiencing domestic abuse, not being taken to planned health and social care appointments, not taking, and not ordering of medication prescribed by the GP. Finances may also be a factor when paying for care services, they may seem disorganised with finances or unable to pay when they are on the relevant benefits.

Using your professional curiosity and asking those additional questions may support you in your practice. We may also have to ask difficult questions or gently challenge a person to achieve the best outcome for the individual.

6.4.7 *Trust* - A person may feel anxious about dealing with staff from Adult or Children's Social Care or any other interested agency, so ensure that the person has access to independent support, advice or advocacy in these circumstances.

6.4.8 Factors which professionals may find more complex when assessing capacity include:

Fluctuating capacity – this may occur due to the nature of the condition they have. In these circumstances it is important assess over a period of time (at different times of the day) and to consider whether the decision to be made is 'one off' or 'repeated decisions'. A person presenting with fluctuating capacity will need regular reviews of their decision-making ability.

Executive functioning/capacity – a person may give superficially coherent answers to questions but are unable to follow through the actions (they can 'talk the talk, but not walk the walk'). Is the person able to use/weigh the information given? Are they able to identify the possible risks and understand the consequences of their behaviour? *Refusal to participate in the capacity assessment* – a person may decline to take part in a capacity assessment. It is important to understand if they are *unwilling* or *unable* to take part. Has the person been involved in discussions about why the assessment is being undertaken? What has been done to engage the person? Are there other people who could support? Is there any coercive or controlling behaviour on the part of a third party? If the risks are high then an application to court may be needed to decide whether the person has or lacks capacity to make the relevant decision.

7. Best Interests

7.1 The MCA provides a checklist of factors that decision-makers must work through in deciding what is in a person's best interests (chapter 5, MCA). The person's current wishes and feelings should be taken into consideration as well as any known previous wishes and feelings. Also, carers and family members have a right to be consulted. Please note that consultation does not have to be in the format of a formal meeting; it can be through one to one consultation, group consultation, by telephone or in person.

As MCA is timely and decision specific, it is important to ensure that decisions are taken promptly, and unless absolutely necessary, arranging a Best Interest Meeting should not delay the outcome of making a decision in the persons best interest. Best Interest Meetings should only be held in relation to complex decision making

Encourage participation

- Do whatever is possible to permit and encourage the person to take part or to improve their ability to take part on making the decision
- Identify all relevant circumstances
- Try to identify all the things that the person who lacks capacity would take into account if they were making the decision or acting for themselves

Find out the person's views, try to find out the views of the person who lacks capacity, including

- The person's past and present wishes and feelings – these may have been expressed verbally, in writing or through behaviour or habits
- Any beliefs and values (e.g., religious, cultural, moral or political) that would be likely to influence the decision in question
- Any other factors the person themselves would be likely to consider if they were making the decision or acting for themselves
- Avoid discrimination

Do not make assumptions about someone's best interests simply on the basis of the person's age, appearance, condition or behaviour

- Assess whether the person might regain capacity

  Consider whether the person is likely to regain capacity (e.g., after receiving medical treatment)

  If so, can the decision wait until then?

- If the decision concerns life-sustaining treatment

  Do not be motivated in any way be a desire to bring about the person's death

  You should not make assumptions about the person's quality of life

- Consulting others

  If it is practical and appropriate to do so, consult other people for their views about the person's best interests and to see if they have any information about the person's wishes and feelings, beliefs and values. In particular, try to consult:

  Anyone previously named by the person as someone to be consulted on either the decision in question or on similar issues

  Anyone engaged in caring for the person, close relatives, friends or others who take an interest in the person's welfare, for example, biological/non-biological family, next of kin, nearest relative, GP, social walker, nurse and any other allied health professional (physiotherapist, occupational therapist, speech and language therapist)

  Any attorney appointed under a Lasting Power of Attorney or Enduring Power of Attorney made by the person

  Any deputy appointed by the Court of Protection to make decisions for the person

For decisions about major medical treatment or where the person should live and where there is no-one who fits into any of the above categories, an Independent Mental Capacity Advocate (IMCA) must be consulted.

8. Capacity and Covert Medication

8.1 Covert medicines should only be used in exceptional circumstances and, where it is considered to be necessary, in accordance with the Mental Capacity Act. Covert medication is an interference with an individual's right to respect for private life under Article 8 of the ECHR and such treatment must be administered in accordance with the law and a procedure that guarantees proper safeguards. Treatment without consent is also potentially a restriction contributing to the objective factors creating a Deprivation of Liberty within the meaning of Article 5 of the Convention. Medication without consent and covert medication are aspects of continuous supervision and control that are relevant to the existence of a Deprivation of Liberty and a consideration of the principle of less restriction and how that is to be achieved must be considered.

8.2 The issue of covert medication is a Best Interests specific decision with significant implications. An example would be someone with a learning disability who lacks capacity to make a decision about treatment for a serious heart condition. The Best Interests decision is to give the medication in the least restrictive way e.g. mixed with food or drink. For covert medication to be given it would first need to be established that the person concerned lacked capacity to consent to taking the medication. 11

8.3 Disguising medicine in the absence of informed consent maybe regarded as deceptive. However, a clear distinction should always be made between:

- Those patients/clients who have the capacity to refuse medication and whose refusal should be respected
- And those who lack this capacity

A further distinction should be made between:

- Those for whom no disguising is necessary because they are unaware that they are receiving medication; and
- Others who would be aware if they were not deceived into thinking otherwise

8.4 As a general principle, by disguising medication in food or drink, the person is being led to believe that they are not receiving medication, when in fact they are. The staff member will therefore need to be sure that what they are doing is in the Best Interests of the patient/client and be accountable for the decision. Such treatment must be necessary in order to:

- Save life or
- Prevent deterioration or
- Ensure an improvement in the patient's/client's physical or mental health

8.5 In the circumstances in which covert administration is agreed as the Best Interests plan the following pointers should be taken into account:

- The decision to administer a medication covertly **must not be considered routine** and should only ever be a contingency measure and decisions should be made for each individual medication
- The patient/client must have been assessed for capacity under the Mental Capacity Act and this should be clearly documented.
- Where incapacity is identified, the best interests of the patient/client must be considered
- Any decision to administer a medication covertly should only be made after full consultation with the multi-professional clinical team (especially the pharmacist), carers, relatives, the relevant person's representative and advocates. If there is no agreement, there should be an application to the Court of Protection.

- Review all medication
- Is the medication still required?
- Is the medication available in an alternative form (e.g., liquid) that would be acceptable? A change of medication will trigger a review.
- Consider palatability, safety and stability of medicines. For stability, consider whether the chemical components would be altered should it be crushed or capsule split. Where needed, obtain advice from the Pharmacy Department
- Regular reviews must be undertaken in consultation with the multi-professional clinical team (especially the pharmacist), carers, relatives, the relevant person's representative and advocates. A review date must be discussed and documented when the initial decision to administer medication covertly is made. The frequency of the review should also be documented at this time
- The rationale, decision and action taken to administer medication covertly must be clearly documented in the person's medical records and include all the names of the parties concerned. This documentation should be easily accessible on viewing any of the person's records within the care/nursing home/community
- Regular attempts should be made to encourage the person to take their medication, preferably by the team member who has the best rapport with the individual. Equally, the person's relative, friend or advocate may be asked to assist with the administration of the medication

8.6 In summary, where there is a Best Interests decision to administer medication covertly, this should occur only in exception cases after consideration of the least restrictive options. The rational for this decision and its review date must be documented. Further guidance can be found here

9. Taking Photos/Audio/Visual Recording

9.1 Consent

Informed consent should be gained from all people before they are photographed. This should be gained by the person who requests the images, who should document this. The person should be competent to take the particular decision, received enough information to take it, and not be acting under duress. The requester should explain to the person, and their carers/family members:

- The purpose of the photographs
- Where the images will be stored
- How the images will be used

Generally, most health and care records are kept for eight years after the person's last treatment. It should be made clear to them that refusal for the pictures to be used for teaching or publication will not affect any care.

9.2 Mental capacity and consent for photography

Where individuals who appear to lack mental capacity to give informed consent need to have photographs taken, family, carers, or an Independent Mental Capacity Advocate (IMCA) may be able to help professionals communicate with a person to establish their wishes. If a person has been assessed as lacking mental capacity to give consent, professionals can still request recording of a patient if it is felt to be in their best interests.

10. Independent Mental Capacity Advocate (IMCA)

10.1 An IMCA is someone appointed to support a person who lacks capacity but has no one to speak for him or her. The IMCA makes representations about the person's wishes, feelings, beliefs, and values, at the same time as bringing to the attention of the decision-maker all factors that are relevant to the decision. The IMCA can challenge the decision-maker on behalf of the person lacking capacity if necessary.

10.2 Arrangements must be made to allow the IMCA to meet the person concerned and see the relevant health, social services and care records. This is to enable the IMCA to perform the function of representing and supporting the person who lacks capacity.

10.3 The Mental Capacity Act places an obligation on Local Authorities and/or NHS bodies to instruct and consult an IMCA when making decisions for a person who lacks capacity regarding the following areas:

- An NHS body is proposing to provide serious medical treatment or
- An NHS body or local authority is proposing to arrange accommodation (or change of accommodation) in hospital or a care home; and
- The person will stay in hospital longer than 28 days, or
- They will stay in the care home for more than 8 weeks

10.4 An IMCA may be instructed to support someone who lacks capacity to make decisions concerning:

- Care reviews, where no-one else is available to be consulted
- Adult protection cases, whether or not family, friends or others are involved
- Where disagreements are noted from concerned parties, the Local Authority may also instruct an IMCA to engage in a case

10.5 The current IMCA service is provided by Ncompass. IMCAs:

- Support and represent the person in the decision making process
- Try to work out what the person would choose if they were able to make the decision themselves
- Speak up for a person in talks and meetings where decisions are being made
- Consult with others in the person's life, including medical staff
- Look at alternative course of action (least restrictive option)
- Ensure the decision complies with the MCA and it is in the person's best interest
- Prepare a report (decision maker has a legal duty to consider this)

- Challenge the decision (including capacity), if necessary

10.6 A referral for an IMCA can only be made by a Health or Social Care professional. The Bury Advocacy Hub offer a single point of contact for all advocacy enquiries in the area. For more information or to make a referral:

Tel: 0300 3030 206 Email: referral@buryadvocacyhub.org.uk Website: https://www.n-compass.org.uk/our-services/advocacy/bury-advocacy-hub

11. Restraint

11.1 The Mental Capacity Act **does not authorise restraint of a person unless two additional conditions are met**: (see section 6(4) of the MCA).

- Reasonable belief that restraint is necessary to prevent harm to the person who lacks capacity
- The restraint must be proportionate to the likelihood and seriousness of the harm

11.2 Restraint is defined as the use, or threat to use, force to secure the doing of an act which the person resists or restricting the liberty of movement whether or not person resists. In line with the rest of the Act, the restraint must also be in the person's best interests and consider if there is a less restrictive alternative.

11.3 Section 6(5) makes it clear that it does not provide any protection for an act depriving a person of his or her liberty within the meaning of Article 5(1) of the European Convention on Human Rights.

11.4 It is important that in circumstances where a person who lacks capacity is refusing or resisting care or treatment that discussions and concerns should be escalated to ensure that appropriate care is delivered. However, where immediate risk is apparent intervention should occur under common law.

12. Protections and Safeguards

12.1 **Lasting Power of Attorney (LPA)**

12.1.1 The MCA allows a person to appoint an attorney to act on their behalf if they should lose capacity in the future. The MCA allows people to let an attorney make health and welfare decisions. In cases of disagreement, this can be challenged through the Court of Protection.

Use this link to find out if someone has a registered attorney or deputy before giving them the power to make decisions.

12.2 A Lasting Power of Attorney (LPA) can only be made while the person granting the power is in a position to make their own decisions. If a client lacks capacity to make their own decisions, then an LPA can be granted and a court order will be required.

12.1.3 An LPA can be used only when it has been registered by the Office of the Public Guardian. Conditions of use and restrictions can be placed in the LPA:

- It **can only be activated when an individual has lost capacity** to deal with their affairs
- Identifies which decisions can and cannot be made

12.1.4 The person appointed is not allowed to make decisions that will benefit them, and they must always act in the person's best interests.

12.1.5 A person can be appointed as an attorney if they are over 18, including a relative, a friend, a professional (like a solicitor), or husband, wife, or partner.

12.1.6 A person cannot be appointed as an attorney to deal with finance and property matters if they are under 18, unable to make their own decisions or subject to a debt relief order or currently bankrupt.

12.2 Endurance of Existing Powers of Attorney

12.2.1 All care staff should be aware that Existing Enduring Powers of Attorney (EPAs) will continue following implementation of the Act. They are not automatically replaced by LPAs nor will EPAs need to apply to become LPAs.

12.2.2 You can ask the Office of Public Guardian's to register a lasting power of attorney. It cannot be used until it has been registered.

12.3 Court Appointed Deputies

12.3.1 The MCA provides for a system of court appointed deputies. Deputies are able to make decisions on welfare, healthcare and financial matters as authorised by the Court but will not be able decide to refuse consent to life-sustaining treatment. They will only be appointed if the Court cannot make a one-off decision to resolve the issues.

12.4 Advance Decisions to Refuse Treatment

12.4.1 Statutory rules with clear safeguards will confirm that people may make a decision in advance to refuse treatment if they should lose capacity in the future. The decision must be made by a person who is 18 or over at a time when the person has capacity to make it and must specify the treatment that is being refused. The person may withdraw this advance decision at any time by any means except in the case of life-sustaining treatment where the withdrawal must be in writing. (5.4.5 Code of practice).

12.4.2 If there is doubt or dispute about the existence, validity or applicability of an advance decision then it should be referred to the Court of Protection for determination.

12.4.3 The advance decision to reduce treatment does not supersede the powers to give medical treatment under Section 3 of the Mental Health Act.

12.5 **Court of Protection and Office of the Public Guardian**

12.5.1 The MCA provides for two public bodies to support the statutory framework, both of which will be designed around the needs of those who lack capacity:

- *The Court of Protection* – a specialist Court which has jurisdiction relating to the MCA and will be the final arbiter for capacity matters. It has its own procedures and nominated judges who appoint deputies to make decisions in the best interest of those who lack capacity to do so. For further information and guidance, see: http://www.justice.gov.uk/courts/rcj-rolls-building/court-of-protection

- *The Office of the Public Guardian* and his/her staff will be the registering authority for LPAs and deputies. They will supervise deputies appointed by the Court and provide information to help the Court make decisions. They will also work together with other agencies such as the police and social services to respond to any concerns raised about the way in which an attorney or deputy is operating. A Public Guardian Board will be appointed to scrutinise and review the way in which the Public Guardian discharges his/her functions, see: http://www.justice.gov.uk/about/opg

13. Mental Health Offences

13.1 The Mental Capacity Act creates the criminal offences of ill-treatment or wilful neglect under Section 44 based on existing principles (under Section 127(1) of the Mental Health Act 1983).

13.2 The elements to be considered about the alleged offender are:

- is the care of the person in question OR is the power of attorney OR is a court-appointed deputy.
- reasonably believes the person lacks capacity (or they do lack capacity).
- that they ill-treat or wilfully neglects the person.

13.3 It can be expected that ill-treatment will require more than trivial ill-treatment and will cover both deliberate acts of ill-treatment and also those acts which could be considered to be reckless.

13.4 Wilful neglect will require a serious departure from the required standards of treatment and usually requires a person has deliberately failed to carry out an act that they were aware they were under a duty to perform. In consequence, defences could be raised to the effect that the elements of the offence set out in Section 44 are not made out in the following terms:

- there is no Section 44 relationship (no care/power of attorney/court-appointed role)
- the person does not lack capacity and/or there was no reasonable belief in such a lack of capacity
- there was no ill-treatment or wilful neglect.

13.5 If ill-treatment or wilful neglect is suspected, the police will consider all available evidence to them at the time, and apply the threshold test on a case-by-case basis to make a decision to put the case forward to the Crown Prosecution Service or to refer to partner agency for further investigation.

13.6 The Criminal Justice and Courts Act 2015 (CJCA 2015) makes it a criminal offence for a care worker to ill-treat or wilfully neglect an individual.

13.7 If any partner agency suspects ill-treatment or wilful neglect, it is their responsibility to make a referral to the police.

14. Deprivation of Liberty Safeguards (Adults – 18 years old+)

14.1 The MCA 2005 provides a statutory framework for acting and making decisions on behalf of those who lack the capacity to make those decisions for themselves.

14.2 The Deprivation of Liberty Safeguards (DoLS) aims to prevent the unlawful detention of adults, in hospitals and care settings, who lack capacity to choose where they live and/or to consent to care and treatment.

14.3 The Supreme Court has now confirmed that to determine whether a person is deprived of their liberty, there are two key questions to ask, described as the *'acid test'*:

- Is the person free to leave?
- Is the person subject to continuous supervision and control?

14.3.1 Whether or not the person objects to the arrangements, and even though the arrangements may be considered to be in the person's best interest, are irrelevant.

14.3.2 This now means that if a person lacks capacity to consent to the care and/or treatment arrangements, is not free to leave and is subject to continuous supervision and control, they are deprived of their liberty.

14.3.3 The Judgement also advises that a low threshold should be used in applying the 'acid test' given the vulnerability of people who are likely to be deprived of their liberty and the intention that the Deprivation of Liberty Safeguards should be protective of such people. The Deprivation of Liberty should only be authorised for the minimum time possible.

The R (Ferreira) v HM Senior Coroner for Inner South London case established that a person is generally not deprived of their liberty when they are receiving life-saving treatment for a physical illness in an intensive care unit (ICU). The case was named after Maria Ferreira, a woman with Down's syndrome and learning disabilities who died in 2013 after being admitted to ICU with pneumonia and heart problems.

14.4 A deprivation of a person's liberty must be authorised in accordance with the law in one of the following ways:

- Residential care homes/nursing homes - authorisation via Deprivation of Liberty Safeguards.
- Mental Health Wards/Hospitals - authorisation via the Mental Health Act on Psychiatric wards or application for DoLS.
- Acute Hospitals – authorisation via Deprivation of Liberty Safeguards.

14.5 In other settings e.g. community settings such as home, supported living placements/extra care such as adult family placements; authorisation is via the Court of Protection (you will need to obtain specific legal advice regarding the steps you need to take in these circumstances).

14.6 Anyone can request a deprivation of liberty assessment but in general it will be the role of the Managing Authority (care home or hospital) to alert the Supervisory Body (Bury Council) who instruct and authorise assessments from a Best Interests Assessor and Mental Health Section 12 Assessor.

14.7 Everyone on a DoLS authorisation will have a representative, either a family member or a friend OR a paid representative (relevant persons representative) if no family/friends are identified to take on this role.

14.8 Independent Mental Capacity Advocates (IMCAs) will represent a person being assessed by a Best Interests Assessor if they have no friends or family to represent them. An Independent Mental Capacity Advocate will also be available to provide support to family or friends acting as representatives (See Section 11 in this document on IMCAs).

14.9 A deprivation of liberty can occur in community and domestic settings where the State is responsible for imposing such arrangements. This will include a placement in a supported living arrangement. Hence, where there is, or is likely to be, a deprivation of liberty in such settings, this should be authorised by the Court of Protection.

14.10 Examples of liberty restricting measures include:

- Decision on where to reside being taken by others
- Decision on contact with others not being taken by the individual
- Restrictions on developing sexual relations
- Doors of the property locked and/or bolted for security reasons or to prevent the young person from leaving
- A member or members of staff accompanying the person to access community support and meet their care needs
- Access to the community being limited by staff availability
- Mechanical restraint, such as wheelchairs with a lap strap or specialist harness
- Varying levels of staffing and frequency of observation by staff
- Provision of ‘safe places’ or ‘chill out’ rooms or spaces during the day or night from which the person cannot leave of their own free will
- Restricted access to personal allowances
- Searching of the person and/or their belongings
- Restricted access to personal belongs to prevent harm
- Medication with a sedative or tranquilising effect
- Physical restraint/intervention such as with personal care tasks, breakaway or block techniques, distraction methods, staff withdrawing, physical touches or holds (e.g., ‘Team Teach’ methods)

- Restricted access to modes of social communication such as internet, landline or mobile telephone or correspondence
- Positive behavioural reward systems to reward' 'good' behaviour
- Disciplinary penalties for poor behaviour
- Restricting excessive pursuance of activities
- Lack of flexibility in terms of having timetabled, set mealtimes, expected sleep times
- Managing food intake and access to it
- Police called to return the person if they go missing
- Restricted access to parts of the property such as the kitchen or certain cupboards therein to minimise health and safety risks

15. How Does the Act Apply to Children and Young People?

15.1 For further guidance we recommend staff refer to Chapter 12 in the Mental Capacity Act Code of Practice.

15.2 The MCA applies to young people 16+ with capacity issues and it can also apply to under 16's in the following circumstances:

- Where the child has an impairment of mind or brain and lacks capacity currently and is likely to still lack it for financial purposes at 18 years (section 2.6 of the MCA).
- Offences of ill treatment or wilful neglect of a person without capacity can also apply to victims younger than 16 (section 44 of the MCA).

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

15.3 Most of the Act applies to young people aged 16-17 years, who may lack capacity within section 2(1) to make specific decisions. There are three exceptions:

- Only people aged 18 and over can make a Lasting Power of Attorney.
- Only people aged 18 and over can make an advance decision to refuse medical treatment.
- The Court of Protection may only make a statutory will for a person aged 18 and over.

16. Deprivation of Liberty (Young People)

16.1 A 'young person' refers to a 16- or 17-year-old. The relevance of Article 5 ECHR to young persons who *lack capacity* to decide where to reside in order to receive care and treatment is the focus of this section.

16.2 DoLS relating to adults is very different to Deprivation of Liberty applied to young people. DoLS for adults refers to the *process* of applying and authorising safeguards for people who are deprived of their liberty in care settings and hospitals. The principle of Deprivation of Liberty and young people relates predominantly to those 16 or 17 year olds who *lack capacity* and are placed in foster homes, children's homes and residential special schools, have liberty restricting measures put in place

and meet the criteria for the nuanced 'acid test' (the young person is under the complete supervision and control of those caring for them and is not free to leave the place where they live). Neither DoLS nor the Mental Health Act 1983 are available to authorise deprivations of liberty here, so judicial authorisation will be required. The Court of Protection can authorise the deprivation of liberty of young person's lacking the relevant mental capacity. The inherent jurisdiction of the High Court is also available, regardless of the person's age.

16.3 If a young person is deprived of their liberty, the consent of those with parental responsibility cannot be relied upon to authorise it as the decision falls outside the scope of parental responsibility. This would apply as equally to local authorities sharing parental responsibility under a care order as it does to parents.

16.4 If you are supporting a young person who is 16 or 17 years old who you have assessed as lacking capacity to make decisions about their care and treatment and you believe they are being deprived of their liberty, discuss the case with your manager as further legal advice will be needed.

16.5 The UN Convention on the Rights of the Child (UNCRC) outlines the fundamental rights of very child. The Convention has 54 articles that cover all aspects of a child's life. Article 3 states the best interests of the child must be a top priority in all decisions and actions that affect children.

17. Excluded Decisions

17.1 The MCA sections 27-29 lists certain decisions that can never be made on behalf of a person who lacks capacity. They are as follows (Extract from MCA 2005 sections 27, 28 & 29).

17.2 *Section 27 Family relationships etc.*

(1) Nothing in this Act permits a decision on any of the following matters to be made on behalf of a person -
(a) consenting to marriage or a civil partnership,
(b) consenting to have sexual relations,
(c) consenting to a decree of divorce on the basis of two years' separation,
(d) consenting to the dissolution order being made in relation to a civil partnership on the basis of two years' separation,
(e) consenting to a child's being placed for adoption by an adoption agency,
(f) consenting to the making of an adoption order,
(g) discharging parental responsibilities in matters not relating to the child's property
(h) giving consent under the Human Fertilisation and Embryology Act 1990(c.37)

(2) "Adoption order" means –
(a) an adoption order within the meaning of the Adoption and Children Act 2002 (c. 38) (including a future adoption order), and
(b) an order under section 84 of that Act (parental responsibility prior to adoption abroad).

17.3 *Section 28 Mental Health Act matters*

(1) Nothing in this Act authorises anyone –
(a) To give a patient medical treatment for mental disorder, or
(b) To consent to a patient being given treatment for mental disorder,
If, at the time when it is proposed to treat the patient, his treatment is regulated by Part 4 of the Mental Health Act 1983.

(2) "Medical treatment," "mental disorder" and "patient" have the same meaning as in that Act.

17.4 *Section 29 Voting rights*

(1) Nothing in this Act permits a decision on voting, at an election for any public office or at a referendum, to be made on behalf of a person.

(2) "Referendum" has the same meaning as in section 101 of the Political Parties, Elections and Referendums Act 2000 (c. 41).

17.5 *Section 62 Unlawful killing or assisting suicide*

For the avoidance of doubt, nothing in the Act is to be taken to affect the law relating to murder, manslaughter or assisting suicide.

18. Procedure

The following procedures apply to all staff as defined in the above scope who are working with adults who may lack the capacity to consent to their care or treatment, including in circumstances that might be considered a deprivation of liberty.

Assessing Mental Capacity

Firstly, adhere to MCA Policy key five principles

- Assume capacity unless it is proved otherwise
- Give all appropriate help before concluding someone cannot make their own decisions
- Accept the right to make what might be seen as eccentric or unwise decisions
- Always act in the best interests of people without capacity
- Decisions made should be the least restrictive of their basic rights and freedoms

When to Assess Capacity?

- Ask the question 'do you have reasonable cause to doubt this person has capacity to make this specific decision' and record in your case notes
- You suspect a person has an impairment or disturbance of mind/brain that is affecting their ability to make the decision under consideration
- The person is unable to make a specific decision due to the impairment and the functioning or disturbance of mind/brain at the time the decision needs to be made

- If there is more than one decision to be made then a capacity assessment should be done for each decision

Who Should Assess Capacity?

- The person directly concerned with the individual at the time – **the Code of Practice is not prescriptive**
- For more complex situations, it may be another professional depending on the situation
- For example, if it is a 'clinical' decision about medical treatment, a doctor/consultant/nurse should assess. If it is a decision to go into a care home, a social worker would be best placed. If it is a legal decision (sign a Will or LPA), a solicitor should assess
- Assess capacity

If the Person Has Capacity?

- Person must be able to make a decision for themselves
- Given the learning from previous Safeguarding Adult Reviews, it is vital that professionals indicate that they have considered someone's capacity and recorded that the person has the capacity to make that decision if they have considered it. This does not remove any other professional duties that you have to protect people and keep them safe from risk or harm via good risk assessment / good risk appraisal.

If the Person is Lacking Capacity – Best Interests Decision Making

- Complete Best Interests Decision
- Consider relevant party's best interest consultation
- Does the person require representation from an IMCA?
- Implement best interests decision

Decision Makers for Best Interests?

- The MCA allows Lasting Powers of Attorneys or Court Deputies to be granted if required
- The statutory best interest checklist should be considered
- The decision maker may consider the need for an IMCA
- Can the decision be considered at a later date?
- Meeting or discussion?
- Best Interests guidance
- In very complex cases, you may need to discuss with line manager and/or legal team

Where and how is the Assessment Recorded?

Capacity assessments must be *decision and time specific, evidence based, person-centred and non-judgmental.* Professionals need to engage with the person to understand who they are, free of pre-judgment and stereotype.

The Mental Capacity Assessment/Best Interests Decision form is to be completed or written in the person's records (refer to your own agencies recording forms).
The Important Factors to Consider when Recording:

- Be clear about the capacity decision that is being assessed
- **Ensure that the person (and you)** have the concrete details of the choices available (e.g., between living in a care home and living at home with a realistic package of care)
- Identify the salient and relevant details the person needs to understand/comprehend (ignoring the peripheral and minor details)
- Demonstrate the efforts taken to promote the person's ability to decide and record this. One of the founding principles of the Mental Capacity Act is maximisation of capacity, this includes ensuring that communication and the way information is presented around the capacity decision is given to the individual, to ensure that their engagement is maximised throughout the decision and best interest process. For example this might include consideration of cultural needs, use of translators, use of speech and language boards, speech and language therapists.
- Assessment is not necessarily a one-off matter, record that you have taken the time to gather as much evidence as is required to reach your conclusion – including, for instance, returning to have a further conversation with the person or obtaining corroborative evidence
- Verbatim notes of questions and answers can be particularly valuable in the record of the assessment
- **Do not assert an opinion unless it is supported by a fact**
- You must also be prepared to justify a decision not to carry out an assessment where, on the face of it, there appears to be a proper reason to consider that the person is able to make the specific decision. If the person is deemed to have capacity, but the risks are high and a multi-agency approach is required, the Multi Agency Risk Management Strategic Risk Panel Policy and Procedure should be followed
- **Whilst the presumption of capacity is a foundational principle, you should not hide behind it to avoid responsibility for an individual**. This can happen most often in the contact of self-neglect where it is unclear whether or not the person has capacity to make decisions
- If you are assessing a person's capacity to make a number of different decisions, it is important to take a step back and ask before reaching a conclusion as to the person's decision-making capacity in relation to each decision
- Evidence each element of your assessment

  (i) Why could P not understand, or retain, or use/weigh, or communicate in spite of the assistance given?
  (ii) What is the impairment/disturbance? Is it temporary or permanent?
  (iii) How is the inability to decide caused by the impairment/disturbance (as opposed to something else)?
  (iv) Why is this an incapacitated decision as opposed to an unwise one?

Additional guidance is available from 39 Essex Chambers in relation to Carrying Out and Recording Capacity Assessments and Relevant Information for Different Categories of Decision.

19. Information Sharing and Confidentiality

19.1 Data Protection Act 2018/General Data Protection Regulation 2018

The Data Protection Act is not a barrier to sharing information but provides a framework to ensure that personal information about living persons is shared appropriately. Be open and honest with the person (and/or their family where appropriate) from the outset about why, what, how and with whom information will, or could be shared, and seek their agreement, unless it is unsafe or inappropriate to do so. It allows for the sharing of data where it is necessary in the public interest or for the performance of an official safeguarding function by the organisation in line with Article 6 (1)(e) GDPR and as such consent from the adult is not required. Circumstances include:

- Where one or more partners have reason to believe that an adult is at risk of death or serious injury as a result of actions/inaction by the adult and/or the actions of others
- The sharing of information is in the public interest and it outweighs the public interest served by protecting confidentiality – e.g., where serious harm may be prevented
- Other people are at risk which may include children or other adults with care and support needs
- An organisation/practitioner feels that there has not been an appropriate response to a safeguarding concern and information sharing is required as part of the escalation process
- The risk to the adult and/or others is considered to be high and meets the criteria for a multi-agency risk assessment under the Multi Agency Risk Management Strategic Risk Panel.
- Where a serious crime has been committed
- Where the person lacks the mental capacity to make the decision – this must be properly explored and recorded in line with the Mental Capacity Act

Information Sharing and Confidentiality

19.2 Third Parties

Sometimes, third parties may request information about someone who lacks capacity. Chapter 16 of the Mental Capacity Act Code of Practice offers general guidance. More specific advice can be obtained from your organisations legal service or from the Information Commissioners at www.ico.gov.uk

20. Resolving Disputes

20.1 There is no formal appeals process under the MCA. The MCA provides open, accessible decision-making and everyone who uses the MCA must be open to challenge. At times this can result in disputes. The decision-maker:

- Has the authority to make a decision about someone's capacity and their best interests
- Must follow the process to assess capacity
- Must follow the Best Interests checklist to decide on someone's best interests – this includes consulting other people such as professionals, family and friends and an Independent Mental Capacity Advocate (IMCA), if appropriate

If the decision maker follows the correct steps, they have the authority to make the decision. Other professionals may disagree with the decision-maker's conclusion. It would be appropriate to discuss this openly, perhaps in a Best Interests discussion, to try to resolve any dispute. Within the Best Interest Decision making process, the decision maker has the final authority to make the decision.

20.2 Family, friends or an IMCA may disagree with professional decisions, or there may be disputes in someone's circle of family and friends. A best interests meeting may offer a more formal way of involving family or friends in a decision and enable them to accept the decision.

20.3 If the decision-maker represents an organisation providing care, such as Bury Council, the NHS or a private provider, they need to demonstrate that the care provided by the organisation is better for the person than anything proposed by their family.

20.4 It may be possible to use mediation to enable people to consider a difficult decision. For advice contact the Family Mediation Helpline or the National Mediation Helpline or other local services.

20.5 Whist the above is true, there are cases where a Section 21A appeal or an application to the Court of Protection may be required to ensure the best outcome for the individual is secure. The Court of Protection can make a decision in cases where it is not possible to resolve a dispute. A public authority should seek a Court determination if there is sustained dispute about a decision, although anyone can apply to the Court of Protection. Application to the Court of Protection should be a last resort. In these circumstances get advice from your organisations safeguarding adults and MCA/DoLS leads and the legal department.

21. Making a Complaint

Anyone can make a formal complaint about any services received. People who may lack capacity, or their family or friends, should be offered whatever support they need to make a formal complaint. Follow your organisations complaints procedure.

22. Monitoring and Review

This guidance will be reviewed and updated on an annual basis or where case law directs changes under the MCA.

23. Further Information and Resources

There is a wealth of published advice and guidance on assessment of capacity:

- NICE guidelines
- Mental Health Law Online
- Bournemouth University MCA Toolkit
- Mental Capacity Law and Policy
- 39 Essex Chambers
- BMA Toolkit
- Mental Capacity Act
- Code of Practice: Mental Health Act 1983
- Deprivation of Liberty Safeguards. British Medical Association
- Office of the Public Guardian