Mental Capacity Act Policy

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1. Introduction

Richmond Music Trust (RMT) fully recognises its responsibilities for safeguarding adults and empowering those who are able to make their own decisions. This policy applies to all employees, contractors or volunteers (permanent or temporary) of RMT and those people that perform work on behalf of RMT.

RMT is committed to supporting people to make as many decisions as they are able to do so and believes that the welfare of people is paramount and that at all times people using RMT services have a right to feel safe and protected from any situation or practice that results in them being harmed or at risk of harm.

> *This is one of the most important pieces of legislation affecting health and social care that we have seen in my time here. It provides a framework to empower and protect individuals who lack the capacity to make decisions for themselves. These principles are honourable and important, and recognise the state's duty to uphold public safety while respecting the dignity and worth of each human being."* - Baroness Finlay, speaking about MCA in the House of Lords, March 2009

This policy complies with the Care Quality Commission Requirements, the Mental Capacity Act (2005), the Mental Capacity Amendment Act (2019), the Local Authority Safeguarding Adults Boards guidance and reflects the principles of the Safeguarding Vulnerable People in the NHS-Accountability and Assurance Framework 2015, The Human Rights Act (1998).

This Policy & Guidelines document has been devised to provide guidance on both the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards 2009 (DoLS). The document therefore has two main sections to separate out the different categories of use and then a third part including helpful references and appendices, in particular the forms adopted to record mental capacity assessments, best interests decisions and to make an IMCA referral. The forms have been adopted to support evidencing best practice.

The Mental Capacity Act and Deprivation of Liberty Safeguards (MCA & DoLS) Guidelines do not replace the Mental Capacity Act 2005, nor the Deprivation of Liberty Safeguards Amendment or the respective Codes of Practice; rather they aim to provide guidance that interpret and link the information to local best practice. You can download the Mental Capacity Act Code here:
http://www.publicguardian.gov.uk/docs/mca-code-practice-0509.pdf

The Deprivation of Liberty Safeguards Supplement Code is available here:
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_087309.pdf

Staff of RMT must always have regard to the Codes of Practice and evidence their decision making in line with it. If they have not followed the guidance contained in the Codes, they will be expected to give good and valid reasons on why they have departed from it (CoP, p 1-2).

RMT recognises that adults who may lack capacity to make decisions will require support to be able to make as many decisions as they are able. The tuition and therapy provided by RMT may be an important stabilising element in the lives of adults as it provides a regular secure and predictable experience. RMT will endeavour to support through:

- The content of the instrumental music curriculum or music therapy session.
- The ethos of the session which should promote a positive, supportive and secure environment and gives individuals a sense of being valued.

- Ensuring that individuals are supported to make as many decisions as they are able, and where they are not able, a decision is made in the individual's best interests taking into account the views of others with an interest in their welfare.
- Liaising where appropriate with other agencies that support the adult such as Social Care, Mental Health Services and Learning Disability Services.

This policy sets out the arrangements and principles of safeguarding adults and the procedural guidance which accompanies this policy gives guidance to staff on what to do if concerned for the welfare and protection of a vulnerable adult.

This policy relates to all those RMT clients aged 16 years or over, who may lack capacity to make a decision. This policy should be read in conjunction with the RMT Safeguarding Policy: Children & Young People which reflects the Think Family model and the RMT Safeguarding Adults Policy.

The procedural guidance contains a number of appendices to support this policy and procedures including Key Contacts, Training strategy, Care Quality Commission reporting guidance and Safeguarding Adult Reviews.

2. Purpose

- This policy applies to all music therapy staff (permanent, temporary or voluntary) of RMT and those people that perform work on behalf of RMT.

- This policy complements all professional or ethical rules, guidance and codes of professional conduct such as the Health and Care Professionals Council.

3. Roles and responsibilities

- **RMT Board of Trustees**

  - The RMT Board's Safeguarding sub-committee annually review the MCA Policy and recommends any changes to the Board for approval. The sub-committee also responds to immediate issues relating to the MCA.
  - The CEO and DSL are co-opted to the Safeguarding sub-committee and the RMT Board nominates its Chair as their point of contact on MCA issues

- **The Chief Executive (CEO)**

  - The CEO has overall responsibility for the safeguarding arrangements of RMT and those receiving tuition, care or therapy from RMT, and for the performance of RMT in supporting the work of the local Safeguarding Adults Boards. The CEO will be notified of any Adult Safeguarding Reviews or Domestic Homicide Reviews and requirements for representation at the meetings of the Safeguarding Partners for the local authority area. This responsibility may be delegated to other senior managers as required.
  - The CEO is responsible for ensuring that the DSL carry out their responsibilities as listed below and for ensuring that all staff receive the appropriate level of training commensurate with their role.

- **RMT's Designated Lead for Mental Capacity Act**

  - The Designated Safeguarding Lead (DSL) will provide an annual report to the RMT Board of Trustees. Further reports will be provided where appropriate.
  - The DSL will be responsible for ensuring a high quality service for those who may lack capacity to make their own decisions and validly consent to engagement with the RMT.
  - The DSL will ensure that expert advice and support is available to all RMT professionals.
  - The DSL will facilitate training and raise awareness of the MCA in accordance with the RMT Training Strategy.

- **All RMT Music Therapy staff**

  - All staff must be aware of and follow the legislation and guidance regarding the MCA and DoLS and their associated Codes of Practice.
  - All staff must consider, at all times, what is in the best interests of the adult.
  - All staff should be alert to the possibility that an individual may not have the capacity to validly consent to decisions about their own lives. If staff members have concerns about the capacity of an individual to make decisions about their own lives, these should be referred to the DSL. The concerns must be addressed and consideration given for the completion of a Mental Capacity Assessment, or where appropriate information must be shared with the relevant Local Authority if a staff member is concerned that an individual engaging the services of RMT may be unlawfully deprived of their liberty.
  - If the DSL is not available to staff, the local authority MCA Lead can be contacted for advice and guidance. However, all MCA concerns must still be shared with the DSL.
  - If staff feel an adult is in immediate danger due to their lack of mental capacity, staff must call 999 and inform the DSL.
  - The DSL should ensure staff have access to supervision which explores the appropriate application of the MCA in cases where they have concerns an individual engaging with the services of RMT may not have capacity to make decisions.

4. Principles

- The MCA 2005 provides the legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make specific decisions. Everyone working with or caring for an adult who may lack mental capacity must comply with the MCA 2005 and the Code of Practice (2007).

- The MCA 2005 applies to individuals aged 16 and over and sets out five statutory principles as below:

  1. A person, must be assumed to have mental capacity unless it is established that he/she lacks mental capacity S.1(2);
  2. A person is not to be treated as unable to make a decision unless all practicable steps to help him/her to do so have been taken without success S.1(3);
  3. A person is not to be treated as unable to make a decision merely because he/she makes an unwise decision S.1(3);

4. An act done, or decision made, under this Act for or on behalf of a person who lacks mental capacity must be done, or made, in his/her best interests S.1(5);
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 S.1(6).

- This means every person (aged 16 and over) capable of making decisions, has an absolute right to accept or refuse care, treatment or other intervention regardless of the wisdom or consequences of the decision. The decision does not have to be justified to anyone. Without valid consent or without a mental capacity assessment and subsequent best interest decision, any invasion of the body, however well-meaning or therapeutic, will be a criminal assault.

- There is specific guidance that concerns decisions made in emergency situations and in relation to protection from legal liability in latter sections of this document.

5. Where there is an issue about mental capacity

- Where there are doubts about an individual's mental capacity to consent to an action that concerns them, a formal assessment of their mental capacity to make this specific decision must be carried out in line with the five statutory principles, and the Guidance of the MCA 2005 Code of Practice and the following sections of the Mental Capacity Act 2005:

  - A person must be assumed to have mental capacity unless it is established that he/she lacks mental capacity S.1(2).
  - A person lacks mental capacity in relation to a matter, if at the material time, he/she is unable to make a decision for him/herself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain S.2(1).
  - The question of whether a person lacks mental capacity must be decided on the balance of probabilities S.2(4).
  - A person is not to be treated as unable to make a decision unless all practicable steps to help him/her to do so have been taken without success S.1(3).
  - A person is not to be treated as unable to make a decision merely because he/she makes an unwise decision S.1(4).
  - Where a person is unable to make a decision for him/herself, there is an obligation to act in his/her best interests S.1(5).
  - Where a decision relates to life-sustaining treatment, the person making the decision must not be motivated by a desire to bring about death - S.4(5).
  - When determining what is in a person's best interests, consideration must be given to all relevant circumstances, to the person's past and present wishes and feelings, to the beliefs and values that would be likely to influence his decision if he had capacity, and to the other factors that he would be likely to consider if he were able to do so - S.4(6).
  - So far as reasonably practicable, the person must be permitted and encouraged to participate as fully as possible in any decision affecting him - S.4(4)
  - The presumption that the adult has capacity is fundamental to the Act. It is important to remember that the adult has to 'prove' nothing. The burden of proving a lack of capacity to take

a specific decision (or decisions) always lies upon the person who considers that it may be necessary to take a decision on their behalf (or will invite a court to take such a decision). The standard of proof which must be achieved is on the balance of probabilities (S.2(4)). Accordingly, it will always be for the decision-maker to prove that it is more likely than not that the adult lacks capacity.

- It is our policy to follow this approach in all cases.

6. Decisions not covered by the Mental Capacity Act (see p. 17 MCA Code of Practice)

- Mental Capacity Act (2005) (s27) excludes:
  - consenting to marriage or a civil partnership
  - consenting to have sexual relations
  - consenting to a decree of divorce on the basis of two years' separation
  - consenting to the dissolution of a civil partnership
  - consenting to a child being placed for adoption or the making of an adoption order
  - discharging parental responsibility for a child in matters not relating to the child's property, or
  - giving consent under the Human Fertilisation and Embryology Act 1990.

- It is our policy to seek appropriate legal advice through normal channels on a case by case basis where these matters arise. Where the matter is a potential criminal offence, advice from your agency safeguarding lead should be sought.

7. Determining capacity occurs through a two-stage test:

- Determining capacity occurs through a two-stage test:
  1) a diagnostic test – does the individual have an impairment or disturbance in the functioning of the mind or brain, whether temporary or permanent at this specific time - S2(2).
  2) a functional test – can the individual *understand* the information relevant to the specific decision, *retain* the information, *weigh up the pros and cons* and finally *communicate* their decision - S3(1).

- It is our policy to make sure these elements are explored and documented in all capacity assessments taking place under the Mental Capacity Act (2005).8

8. Independent Mental Capacity Advocates

- An Independent Mental Capacity Advocate (IMCA) MUST be appointed where it is determined that an adult lacks capacity and has nobody to support them (other than paid staff) and a specific decision is being made about:
  - A change of accommodation – a move to a care home for more than 8 weeks or an admission to a hospital bed for 28 days OR

- more serious medical treatment.

- 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.

- It is our policy in cases where appointment of an IMCA is optional that a referral to an IMCA is made as this provides better protection for the individual and is likely to result in outcomes that are more sustainable and best value.

9. Advance Decisions

- An adult aged 18 and over can make an advance decision to refuse specific medical treatment if they have capacity. Where such a decision involves life-sustaining treatment it must be in writing, signed and witnessed and state clearly that the decision applies even if life is at risk.

- It is our policy to enquire during all assessments if an adult has made an advance decision and to respect such decisions where they exist. Where an individual has not made an advance decision it is our policy to ensure they are sign-posted to relevant sources of information about advance decisions – such as www.compassionindying.org.uk. Further guidance is contained in the Mental Capacity Act Code of Practice (Chapter 9).

- Professionals should be aware that an LPA(PW) appointed after an Advance Decision has been made can over-rule an individual's advance decision.

10. Court of Protection Deputies,Lasting Power of Attorneys & Health Proxies

- Where an individual has capacity they can choose to appoint a donee of Lasting Power of Attorney who is able to make decisions on their behalf. There are two types of Lasting Power of Attorney:

  1) Property and Affairs LPA – whose powers are limited solely to property and affairs.
  2) Personal Welfare LPA.

  LPA's must be registered with the Office of the Public Guardian.

- It is our policy to enquire during all assessments if such an arrangement exists and to respect such decisions made by an individual where they do exist, subject to our wider safeguarding duties. Where an individual has not appointed an individual to be a donee of Lasting Power of Attorney it is our policy to ensure they are sign-posted to relevant sources of information about the role of Lasting Power of Attorney.

- A donee of Enduring Power of Attorney only has the authority to make decisions about property and affairs. A donee of EPA could only be appointed prior to April 2009.

- Where an individual lacks capacity, an adult can apply to be appointed as a Court of Protection Deputy who is able to make decisions on their behalf. There are two types of Deputies:

    1) Property and Affairs Deputy – whose powers are limited solely to property and affairs.

    2) Personal Welfare Deputy – whose powers relate to the wellbeing of the individual including the care, place of residence and medical treatment of the individual.

- The same person can hold both appointments and are accountable to the Court of Protection. The Court of Protection will only very rarely allow the appointment of a corporate or an individual as a welfare deputy, after the person has lost capacity to appoint an attorney. This means that all major welfare decisions have to be manage through the Court of Protection. It is our policy to ensure that all welfare decisions are properly identified and dealt with in accordance with the relevant legal framework.

- Appointments of LPA and Deputyship can be joint and several.

- It is our Policy to enquire during all assessments if such an arrangement exists and to respect such arrangements where they do exist, subject to our wider safeguarding duties.

- The same principles apply to those who having made an Advance Decision have appointed a health proxy.

11. Restraint

- The right to liberty is a universal right guaranteed by the European Convention on Human Rights to everyone.

- The Mental Capacity Act allows restrictions and restraint to be used in a person's support, but only if this is in the best interests of the person who lacks capacity to make the decision themselves. Restrictions and restraint must be proportionate to the harm the care giver is seeking to prevent, and can include:

    - using locks or key pads which stop a person going out or into different areas of a building.
    - the use of some medication, for example, to calm a person.
    - close supervision in the home, or the use of isolation.
    - requiring a person to be supervised when out.
    - restricting contact with friends, family and acquaintances, including if they could cause the person harm.
    - physically stopping a person from doing something which could cause them harm.
    - removing items from a person which could cause them harm.
    - holding a person so that they can be given care, support or treatment.
    - bedrails, wheelchair straps, restraints in a vehicle, and splints.
    - the person having to stay somewhere against their wishes or the wishes of a family member.

- repeatedly saying to a person they will be restrained if they persist in a certain behaviour.

- Section 6(4) of the Act states that 'someone is using restraint if they:
  - use force – or threaten to use force – to make someone do something that they are resisting, OR
  - restrict a person's freedom of movement, whether they are resisting or not.' (Section 10.4)

- The definition is deceptively short, but is supported by extensive guidelines to assist in its interpretation, and it is, or will be, ultimately interpreted through the decisions of the courts in specific cases.

- In an emergency: if a person who lacks capacity to consent has challenging behaviour, or is in the acute stages of illness causing them to act in way which may cause harm to others, staff may, under the common law, take appropriate and necessary action to restrain or remove the person, in order to prevent harm, both to the person concerned and to anyone else. (Section 6.43)

- Such restrictions or restraint can take away a person's freedom and so deprive them of their liberty. They should be borne in mind when considering whether the support offered to a person is the least restrictive way of providing that support.

- It is our policy that where contact with family or friends is restricted
  - a Safeguarding Alert should be immediately raised by the provider of care
    OR
  - there should be an existing agreed adult protection plan which has concluded that contact should be restricted and a Deprivation of Liberty Safeguards Authorisation supporting that restriction should be sort.

- Restricting contact with friends and family potentially is a breach of an individual's rights under Article 8 of the European Convention on Human Rights and legal advice regarding the necessity to make application to Court should occur where there is a dispute regarding an individual's welfare.

- It is our policy that where it is necessary to physically restrain an individual, the carer who restrains that individual should be appropriately trained in ethical care and restraint techniques. Attempting to physically restrain an individual without appropriate training can result in significant injuries to both the carer attempting the restraint and the individual who is restrained.

- Where an individual's liberty is restricted to:
  - a certain specific place (such as their own home, foster home, supported living accommodation, a care home or hospital bed) - regardless of whether that person is compliant with the arrangements for their care and/or treatment or is requesting to leave –

  AND/OR
  - there is a restriction on contact with family/friends – which lasts for more than a few days

  then this must result in the urgent consideration of the necessity to make an urgent application for a Deprivation of Liberty Safeguards Authorisation. Advice can be sort on whether the threshold to make an application has been reached from the relevant Local Authority Deprivation of Liberty Safeguards (DoLS) Team.

GUIDANCE

1. Assessing Capacity

Stage 1 (the diagnostic test) requires that the individual has an impairment or disturbance of the mind or brain whether temporary or permanent. This does not require that there is a formal diagnosis, but rather that the decision maker believes, on the balance of probabilities and based on information available at the time, that the individual has an impairment or disturbance of the mind or brain.

If an individual does NOT have an impairment or disturbance of the mind or brain whether temporary or permanent then the individual has capacity and you do not proceed to stage 2.

The Diagnostic Test:

Does this indicate that the individual may have an impairment or disturbance of the mind or brain	**Yes or No**
Diabetes resulting in a blood sugar level which is too high or low	Y
Learning disability	Y
Depression	Y
Brain injury	Y
Aspergers	Y
Dyslexia	Y
ADHD	Y
Under influence of substances	Y
Under influence of alcohol	Y
Under the influence of legal highs	Y
Toxic Confusional State	Y
Unconscious	Y

Stage 2 (the functional test)

Can the individual:

1. *understand* the information relevant to the specific decision,
2. *retain* the information,
3. *weigh up the pros and cons* and finally
4. *communicate* their decision - S3(1).

The individual needs to be able to demonstrate all four points above to have mental capacity in respect of a specific decision. If they not able to demonstrate all four points, they do not have mental capacity.

There is no requirement to assess capacity unless there are doubts about the individual's capacity to make a specific decision.

Example: *Jack (82) has complex physical needs and has vascular dementia. He is living in a residential care home and the music therapist is running a weekly music therapy group for residents. The care home manager has asked the senior carers to ensure that Jack attends the music therapy group.*

Amy (the therapist) meets with Jack to tell him about the group and asks if he is willing to attend. She explains that they might sing some songs and play some percussion instruments and she shows him some of the instruments she uses. She talks to Jack about her beliefs about how the therapy might be helpful for him at this time. Amy wishes to check out he understands and is agreeing to attend.

Jack explains he understands perfectly, but he does not want to attend a music therapy group. 82 is a good age and he knows his own mind. He has never much liked music and certainly does not like groups. He has always been a bit of a loner. He notes that he can understand some of the 'old dears here' might enjoy it but he prefers his own company and if he wants to listen to some music he can put some on, on his radio in his room, not mess about with percussion instruments – he has not touched those since he was a lad.

Amy concludes that Jack does understand the information relevant to the decision (about attending a music therapy group) and that there is no requirement to undertake an assessment of his capacity to evidence this and that he is refusing to attend. Amy then records the conversation in the clinical notes and advises the care home manager of Jack's decision. She notes that the Care Home Manager believes Jack is very isolated in the home and that the therapy group would be beneficial to him. Amy agrees she will continue to regularly review with Jack his decision not to attend. Jack is supported and empowered to make a decision not to engage in the group at the present time.

Example*: Julie is a 23 year old with multiple physical health problems and an acquired brain injury after a motor-bike accident. She has a 3 year old son (born before the accident) and lives in supported accommodation. Her son is now cared for by her parents. Prior to the accident she was a talented pianist.*

Julie attends Richmond Music Trust for music therapy. She is bought to sessions by carers and has invested in a piano in her accommodation. Whilst her speech is now slow and sometimes indistinct, you can communicate together verbally. She has difficulties with her balance and possibly her mental health – she is sometimes very tearful during sessions but you are not aware if she has a diagnosed mental illness such as depression.

Julie appears to enjoy her time spent at RMT but struggles with her concentration and does not always remain for the whole session; walking out sometimes after only 10 minutes to her carers in the waiting room. Julie received compensation following the RTA and receives a weekly allowance from her solicitor who is acting as Deputy for finances. She is paying for piano lessons with you through her weekly allowance. You need to be assured Julie has capacity to make her decision to attend piano lessons and to pay for the full hour even when she only remains for 10 minutes.

Your conversation with Julie about the sessions includes exploration of how much she thinks the sessions cost (she has no idea); who she thinks pays for them (she queries if her mum does). You tell Julie she is paying for the sessions and that even when she leaves early she still has to pay for the whole time. Julie is not able to weigh the pros and cons of paying for lessons when she leaves early or to discuss the pros and cons of attending for music lessons although her carers say that when they mention music lessons she is always keen to come to the centre.

You conclude that Julie does not have capacity to make decisions about attending as although Julie appears to enjoy attending she is unable to understand that she is paying for the sessions or to describe any of the pros and cons of attending. A best interests meeting is held with her parents, solicitor and one of her carers. This concludes that the music lessons are in her best interests even if she only attends part of the planned appointment – they are a stable planned event in her calendar which she always appears keen to attend, they are a link with her personality/past pre the brain injury and after attending, Julie appears calmer and more settled. In addition, they are supporting Julie's self-expression.

Julie is continuing to make slow but steady progress following her brain injury and you agree to revisit this assessment on a six monthly basis

2. Who can access capacity?

The Mental Capacity Act is very clear that the individual who is going to take action or make a decision on behalf of an adult should be the person who assesses their capacity, for example:

Decision to be made (P = Person)	**Assessor**
P referred for therapy	The therapist providing the therapy assesses – eg to determine if the individual is able to consent to engage in therapy
P needs to be admitted to a hospital bed	Ward manager, charge nurse, staff nurse or Medic on the ward
P with LD brought by parents for guitar lessons	The guitar teacher. Consent is sought from the 16 year old. If the 16 year old lacks capacity to consent to engage in guitar lessons, then the parents are consulted as part of the Best Interests Decision
P needs to have her incontinence pads changed	Person who is going to change her pads
P needs assistance eating	Person who is providing that assistance
P needs washing or dressing	Person who is providing that assistance
P needs to have a change of accommodation funded by social care	Social Worker
P living independently wishes to have social contact with friends and family who are subject of a safeguarding alert	Professional leading the safeguarding investigation
P needs urgent medical treatment and is unconscious	Medical professional provides treatment without attempting to assess capacity, in best interests (s6.35 MCA Code of Practice)
P wishes to enter into a sexual relationship	This decision lies outside the scope of the Mental Capacity Act but Safeguarding should be considered and legal advice sought as required.

3. Day-to-Day Decisions:

Where paid carers are undertaking the day-to-day care of an individual, they are reminded that an individual needs to validly consent to that care. Where an adult has not validly consented to that care, then carers could potentially face a charge of criminal assault.

In practice, many individuals (such as those living with dementia or a severe learning disability) may be unable to validly consent to a significant number of decisions involving their day-to-day care - such as consenting to assistance with showering or with eating and drinking. In such circumstances, it would get

in the way of the provision care and support if the carer were to have to seek to gain consent (and assess capacity) on every single occasion that assistance was required.

It is our policy that where an individual is referred for therapy or music lessons from RMT that capacity to consent to each separate day-to-day decision should be assessed as part of the initial admission or review process and recorded in their electronic records. Capacity should only be re-assessed if it is considered that capacity has fluctuated. All RMT staff must recognise that an individual may have capacity in respect of some day-to-day decisions (such as choice of clothing) but not others and that capacity can fluctuate over time.

Example: *Ada (16.5 years is self-funded for both a therapy group and separately music lessons by her parents who sought the services of RMT. She has a diagnosis of learning disability and epilepsy, is non-verbal but is able to communicate using a limited number of signs (Makaton). Ada is also familiar with use of a talking mat – pointing to pictures to communicate her wishes.*

On arrival, the music therapist completes an initial assessment, this includes documenting her care needs within a care plan. The MCA presumes Ada has capacity to make all decisions. The therapist meets with Ada in a therapy room where instruments can be seen but also uses a talking mat and signing to communicate with Ada. The therapist notes that Ada is able to make choices about what she likes to eat and which clothes she wishes to wear and what instruments she wishes to play – these choices are evident through Ada pointing to her choices – either physically or by pointing to smiley and sad faces on a talking mat. Her therapist notes that Ada is consistent in her choices.

Ada appears unable to understand the pros and cons of attending a music therapy group or that she will be required to attend every week. The therapist completes the assessment about Ada's ability to consent to engage in music therapy group and concludes that whilst Ada is compliant and enthusiastic about attending, she does not have capacity to weigh up the pros and cons of attending. The therapist consults with Ada's parents and all agree that it is in Ada's her best interests to receive this support. In completing the best interest's decision, the therapist noted the views of Ada's speech therapist and GP, both of whom were supportive of the referral to therapy hoping this would assist Ada's social interaction with others and assist her in making choices.

The music teacher separately meets with Ada whose parents wish for Ada to have guitar lessons. Following her conversation with Ada, she too concludes that Ada does not have capacity to make a decision about consenting to music lessons. She notes that when Ada is asked if she would like to meet with the teacher one-to-one Ada smiles and points to a thumbs up on her talking mat. She responds similarly when asked if she wants to play an instrument, but also gives the same response when asked she would like to climb Everest, do some painting or watch TV.

When asked which instrument Ada points to the piano and a cymbal and a guitar. When asked to choose one, Ada's choices are inconsistent and she struggles to only choose one instrument.

Ada's teacher concludes that Amy does not have capacity to consent to music lessons. This separate assessment is recorded on the MCA form and then a Best Interests meeting is held with Ada and her parents who advise that Ada is generally happy to engage in any activity and that she always smiles when she hears the guitar. They believe that Ada will enjoy one-to-one work and they hope that some of the electronic music options may help Ada to communicate her emotions and provide another means of self-expression. The outcome of these assessments are recorded. Her parents advise that there is no reason to expect Ada's capacity to make decisions will change –they have seen her abilities deteriorate slightly in recent years as a consequence of her epilepsy.

There is no necessity for these capacity assessments to be repeated.

4. Complex Decisions

A complex decision may be one where there are serious or long term consequences for the adult, such as:

- where we need to take decisions in an individual's best interests which involve the disclosure of confidential or sensitive information to a third party such as the Police
- a change of accommodation,
- limitations on who they can associate with,
- medical treatment which will have long term consequences or may endanger life,
- major financial decisions that may involve for example mortgages

This list is not exclusive, but in all these circumstances, assessments MUST be undertaken by an appropriately qualified professional with appropriate support from specialist colleagues such as safeguarding, legal and policy advisors. In cases of doubt about who should appropriately assess, advice should be sought from your agency Safeguarding Lead or from your legal advisor.

Complex decisions should be recorded in considerable detail.

5. How many assessors are needed?

It is **not** a requirement that assessments are undertaken by more than one qualified professional and in most cases this will not be required or appropriate.

Where the matter is likely to involve more than one qualified professional:

- Where it is likely that the adult's family may dispute or complain about the outcome of the capacity assessment
- Where capacity is fluctuating or is borderline
- Restraint
- Where is a known conflict about the care and support of the individual
- Where a known co-dependent relationship is involved which has been a source of conflict or risk

Consideration should be given as to whether there should be a second assessor present at the assessment.

Consideration should always be given to whether the presence of a second assessor may be overwhelming for the adult, if so alternative arrangements for obtaining the specialist input should be explored.

Local arrangements should be in place to monitor and control the use of second assessors to ensure appropriateness and best value.

Example 1: *Jasmine (17) is depressed but is wanting help and has been engaging in therapy with you. She was brought to RMT by her father.*

In the course of her therapy Jasmine has disclosed that her father is abusive to her mother (she gets hit when she tried to intervene to protect her mother) and to her two younger sisters. You have observed what appear to be finger-print marks on her arm. She says her dad was pushing her away when he was arguing with her mum.

She has also told you that her father drives her to therapy because he is furious she self-harmed – he sees this as a criticism of him and their family. Since she self-harmed he will not allow her out alone; he drives her everywhere and the only times she is not watched is when she is in school. You have never met her mother or younger sisters, it is her father who drives her to therapy and collects her afterwards. He has always been very civil to you, asking politely if Jasmine is 'doing well'. You have explained Jasmine's therapy is confidential and you will not share information with him without Jasmine's permission and he has appeared to accept this.

Jasmine says she is worried one day her father will 'really lose it' and someone will be very badly hurt. You advise Jasmine that you need to share this information with the Local Authority through their safeguarding hub (the MASH). This will mean you are breaching her confidentiality and you ask her to consent to her confidentiality being breached. You explain very clearly the process which will occur should you make a referral. You both agree that as Jasmine is 17, she is able to consent to her confidentiality being breached without her parents' knowledge. Jasmine believes if her father is consulted and his agreement sought to the referral, that her father will be furious, will stop her attending therapy and will punish her for talking to her therapist about private family matters.

Jasmine is very scared about information being shared with social care or police. She advises she fears that this will make matters worse. She says that she has looked up information on google and knows that it is going to be difficult for police to prosecute her father as she believes her mother and sisters will be too scared to do anything other than deny anything has happened. She expresses fears that if this happens it would actually make life much more dangerous at home. She says her dad is just a 'control freak' who can't cope now his daughters are older and do not blindly do what he wants all the time. She understands that the therapist feels a referral must be made as she is concerned that interests of children are paramount and that not only Jasmine is at risk but also her younger sisters (aged 11 and 14)

Following lengthy discussions, you agree that Jasmine has capacity. Jasmine's consent to information being shared is conditional that agencies are very aware that any actions proposed and taken should be considered very carefully with acknowledgment that this could escalate risks. Jasmine stated that if her father was aware referral was made by her therapist she would be prevented from attending therapy in the future and she asked that if she stopped attending therapy her therapist should request a welfare check from Police regarding both her wellbeing. You clearly document your conversation with Jasmine and note she has capacity to make this decision

6. Making a decision in an individual's best interests:

Best interests is not defined in the Act but section 4 sets out in detail a checklist of factors which must be considered in determining an individual's best interests. These include the requirement that an individual should take into account the views of 'anyone named by the person as someone to be consulted on the matter in question' or 'anyone engaged in caring for the person or interested in his welfare'. The principle of equal consideration (S.4(1)), reminds decision-makers that they must not make assumptions about what a person's best interests might be simply on the basis of their age, appearance, condition or behaviour and that every effort must be taken not to act in a discriminatory way.

Mental Capacity Act Code of Practice (2007) 6.28 -6.34 states that to demonstrate 'reasonable grounds' in relation to best interests decision-makers should:

- apply all elements of the best interests test (in s.4)
- consider all relevant circumstances
- consider whether the person is likely to regain capacity to make the decision in the future
- consider whether a less restrictive option is available
- have objective reasons for thinking an action is in the best interests of the person who lacks capacity
- be aware that the skills and knowledge of healthcare staff will affect what is classed as 'reasonable', i.e. they should apply normal clinical and professional standards when deciding what treatments to offer.

Important caveats to the determination of best interests are that the decision maker cannot over-rule a valid and applicable advance decision, or the wishes of a registered donee of Lasting Power of Attorney for Personal Welfare. For any decision made or action taken under a best interests decision, regard must be had as to whether the purpose for which it is needed can be effectively achieved in a way that is less restrictive of the person's rights and freedom of action. In determining if a decision is in an individual's best interests, professionals must have a reasonable grounds in relation to their determination of best interests.

The difficulty with the checklist approach detailed in S4 (MCA 2005) is the prioritisation of each factor. The MCA does not specify that more or less weight should be given to any of the factors in S.4(6), and nor does the Code of Practice guide decision makers to prefer any factor. Empirical research reveals that people making best interests decisions take a diverse approach with decision makers attaching value to a range of factors including wider social norms, their own values, their perception of and belief about P's wishes and feelings before P lost capacity, the views of P's carers, or the likelihood of P recovering capacity in the future.

Fair application of the standard of best interests requires that professionals consider the medical, social, psychological and emotional benefits of a decision and that they fully explore with the individual the pros and cons of any proposed decision, providing full information of all potential risks and any reasonable alternatives before determining decisions in best interests.

7. Can a family member or friend be present at the assessment of capacity?

Family members or friends have no right to be present when an assessment of capacity is being undertaken.

It is strongly recommended that a family member should not be present unless the decision maker has clearly documented that the presence of the family member is a practical step which will support the individual to make a decision. Where a family member is present they should be advised that they must not prompt the individual whose capacity is being assessed or lead their family member during the assessment.

Decision makers must be aware that the presence of a family member during the assessment could result in a challenge that the outcome of the assessment is invalid as the individual whose capacity was assessed has been coerced, or has made a decision under duress or undue influence.

It is our policy that family members should only be present in assessments in exceptional circumstances where the decision maker believes this will appropriately support the individual to make a decision.

Where it is determined that an individual lacks capacity and the decision make is consulting with others, then 'remember that the person who lacks capacity to make a decision or act for themselves still has the right to keep their affairs private so it would not be right to share every piece of information with everyone' (MCA Code of Practice, pg 66).

8. Determining capacity to consent where an individual refuses to engage in the assessment:

There are occasions when adults may refuse to engage in assessment of their capacity to make a specific decision.

Where this occurs, professionals should advise the individual they if they decline to engage, they will need to make a determination of the individual's ability to make this specific decision on the balance of probabilities taking into account the knowledge they already have about the individual – their cognitive abilities, diagnosis and presentation.

Where an individual refuses to engage because they do not understand (due to their impairment or disturbance of the mind or brain whether temporary or permanent) then the decision maker can conclude on the balance of probabilities that the individual lack's capacity to make this specific decision.

The 'balance of probabilities' is a social construct however a balance sheet approach should be used to determining whether an individual has or does not have capacity.

Example: *Mavis has severe learning disabilities and physical disabilities and is living in a residential care home. Her carers have identified that she may have an underlying new physical condition. They have called her GP to examine her as they are concerned that she is physically unwell.*

Her GP wishes to take her blood to check if she is anaemic. The GP seeks Mavis's consent to take her bloods but it is apparent that Mavis is non-verbal and is unable to comprehend what the GP is telling her. The GP together with a carer from the care home with whom Mavis has a positive relationship attempt to explain to Mavis through signing and use of a talking mat (communication aids that Mavis is familiar with) however Mavis is becoming agitated and distressed. The GP (who is the decision-maker) concludes on the balance of probabilities that as Mavis appears unable to comprehend the information being provided to her, that she has a known diagnosis of severe learning disabilities, that she appears to be physically unwell and that her carers advise that it is unlikely she would have capacity to consent to this decision, that on the balance of probabilities she lacks capacity to consent to the blood test.

Taking bloods is necessary to ensure Mavis does not have a serious underlying physical condition - consequently the GP prescribes some Diazepam / Valium (a chemical sedative) and uses a topical anaesthetic cream (such as EMLA) to ensure that the blood test can proceed. The diazepam is essentially the lawful use of restraint (under s5 MCA) and is in Mavis's best interests to enable the blood tests to be completed in the least distressing manner.

9. Disputes regarding the outcome of assessments of capacity:

Where there is a dispute or disagreement about the outcome of an assessment of capacity – for example where a professional has concluded an individual does have capacity to decide where they wish to live and a family member is determined that their mother lacks capacity to make this decision then professionals are reminded that it is the decision-maker who has the final determination regarding the outcome of the assessment.

Professionals should take into account the concerns of family or friends if they dispute the outcome of an assessment and where necessary they can request a second opinion or (where a dispute is anticipated prior to the assessment occurring) consider the use of two professionals to jointly assess an individual's capacity to make a specific decision.

Where the decision maker can-not get enough information to reach a conclusion about whether the adult has capacity in relation to a specific decision they may need to consider requesting the support of a colleague with specific expertise such as a speech and language therapist or a neuropsychologist or a mental health professional to help them in determining the outcome of the assessment.

Where having involved a colleague there is disagreement between them about the outcome (ie one concludes on the balance of probabilities that the individual has capacity whilst the other concludes on the balance of probabilities that they do not have capacity), then it must be presumed that the individual does have capacity.

10. Assessments of Capacity for individuals who have a donee of Lasting Power of Attorney or a Court Appointed Deputy:

If a friend or relative states that they are a donee of LPA (Personal Welfare) or a Welfare Deputy, then the decision maker must assure themselves of the validity of this statement by requesting to see a copy of the registration.

Where it is concluded that an individual lacks capacity to make a decision about their personal welfare *and* they have a donee of LPA (Personal Welfare) or a Welfare Deputy, then the decision maker is the donee of LPA (Personal Welfare) or the Welfare Deputy.

If you are concerned that the LPA (Personal Welfare) or a Welfare Deputy is not acting in the best interests of the individual then you must raise an urgent safeguarding alert and discuss the matter with your line manager urgently as legal action may be required.

11. Advance Decisions:

Where an individual has a known degenerative condition or long-term health difficulty such as an enduring mental illness they should be informed and advised of their right to make an advance decision.

Caring for people at the end of their lives is an important role for many health and social care professionals. One of the aspects of this role is to discuss with individuals their preferences regarding the type of care they would wish to receive and where they wish to be cared for in case they lose capacity or are unable to express a preference in the future. These discussions clearly need to be handled with skill and sensitivity. The outcomes of such discussions may then need to be documented, regularly reviewed

and communicated to other relevant people, subject to the individual's agreement. This is the process of Advance Care Planning (ACP).

For individuals with capacity it is their current wishes about their care which needs to be considered. Under the MCA 2005, individuals can continue to anticipate future decision making about their care or treatment should they lack capacity. In this context, the outcome of ACP may be the completion of a statement of wishes and preferences or if referring to refusal of specific treatment may lead onto an advance decision to refuse treatment (Chapter 9 MCA 2005 Code of Practice). This is not mandatory or automatic and will depend on the person's wishes. Alternatively, an individual may decide to appoint a person to represent them by choosing a person (an 'attorney') to take decisions on their behalf if they subsequently lose capacity (Chapter 5 MCA 2005 Code of Practice).

A statement of wishes and preferences is not legally binding. However, it does have legal standing and must be taken into account when making a judgement in a person's best interests. Careful account needs to be taken of the relevance of statements of wishes and preferences when making best interest decisions (Chapter 5 MCA 2005 Code of Practice).

If an advance decision to refuse treatment has been made it is a legally binding document if that advance decision can be shown to be valid and applicable to the current circumstances. If it relates to life sustaining treatment it must be a written document which is signed and witnessed.

In all cases, an individual's contemporaneous capacity must be assessed on a decision-by-decision basis. An individual may retain the ability to make a simple decision but not more complex decisions (Chapter 4 MCA 2005 Code of Practice).

There is no legal template for recording advance decisions and advance directives, however Compassion in Dying (www.compassionindying.org.uk) provide a useful template for recording both advance directives and advance decisions. It is recommended that providers of care use these forms to record advance decisions and advance directives.

It is essential that where an advance decision is made, a copy of this is held in the individual's clinical records and that the individual is encouraged to share copies with family and those health and social care professionals coordinating their care.

An advance decision must be followed where it is concluded that an individual lacks capacity to make a specific decision about their medical treatment and it is known that they have previously made an valid and applicable advance decision (relating to the proposed specific medical treatment).

An advance decision can only be overruled if it relates to treatment of a mental disorder and the individual has been detained under the Mental Health Act (1983). If the individual has made a specific decision to refuse ECT, the guidance in s59-62 of the MHA, (1983) must be followed.

Decision makers are advised to consult senior clinicians as required.

Those working with and caring for individuals with life limiting conditions may find the guidance at www.endoflifecareforadults.nhs.uk, www.ncpc.org.uk or www.compassionindying.org.uk very helpful.

12. Independent Mental Capacity Advocates (IMCA):

Where the decision maker concludes the individual lacks capacity and the threshold for requesting an IMCA has been reached, then there is a statutory duty to provide an IMCA.

An IMCA MUST be appointed where it is determined that an adult lacks capacity and has nobody to support them (other than paid staff) and a specific decision is being made about:

a) A change of accommodation – a move to a care home for more than 8 weeks or an admission to a hospital bed for 28 days or more

b) Serious medical treatment

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

c) Care Reviews – where no-one else is available to be consulted

d) Adult Protection cases – whether or not family, friends or others are involved.

It is our policy in cases where appointment of an IMCA is optional that a referral to an IMCA is made as this provides better protection for the individual and is likely to result in outcomes that are more sustainable and best value.

13. Restraint:

The right to liberty is a universal right guaranteed by the European Convention on Human Rights to everyone. If restraint is necessary in the best interests of the individual, then any restraint used must be a proportionate response to the degree of harm that might otherwise occur. The nature of the restraint used, length of time it lasted and reasons why it was used must be clearly documented.

The Mental Capacity Act allows restrictions and restraint to be used in a person's support, but only if this is in the best interests of the person who lacks capacity to make the decision themselves. Restrictions and restraint must be proportionate to the harm the care giver is seeking to prevent, and can include:

- using locks or key pads which stop a person going out or into different areas of a building
- the use of some medication, for example, to calm a person
- close supervision in the home, or the use of isolation
- requiring a person to be supervised when out
- restricting contact with friends, family and acquaintances, including if they could cause the person harm
- physically stopping a person from doing something which could cause them harm
- removing items from a person which could cause them harm
- holding a person so that they can be given care, support or treatment
- bedrails, wheelchair straps, restraints in a vehicle, and splints
- the person having to stay somewhere against their wishes or the wishes of a family member
- repeatedly saying to a person they will be restrained if they persist in a certain behaviour.

Section 6(4) of the MCA states that 'someone is using restraint if they:

- use force – or threaten to use force – to make someone do something that they are resisting, or
- restrict a person's freedom of movement, whether they are resisting or not.' (Section 10.4)

In an emergency: if a person who lacks capacity to consent has challenging behaviour, or is in the acute stages of illness causing them to act in way which may cause harm to others, staff may, under the common law, take appropriate and necessary action to restrain or remove the person, in order to prevent harm, both to the person concerned and to anyone else. (Section 6.43)

Where-ever possible, carers should seek to minimise the use of restraint. SCIE provide a range of literature designed to provide guidance to carers to minimise the use of restraint in specific settings- see http://www.scie.org.uk/publications/reports/report26.pdf.

Prepared by:	Caroline Peirson, CEO / Andreas Rosenboom, Head of MT (DSL)
Approved by:	RMT Board November 2022
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Review Body:	RMT Board; Safeguarding sub-committee
Responsibility:	Chief Executive

ANNEX 1

Using this form:

Mental Capacity Assessment – for less complex decisions

The Mental Capacity Act 2005 states that anyone can assess another person's mental capacity especially in relation to day to day decisions and simple decisions. Practitioners must abide by the following five statutory principles which are as follows:

1. A person must be assumed to have capacity unless it is established that he/she lacks capacity (by undertaking capacity assessment).

2. A person is not to be treated as unable to make a decision unless all practicable steps to help him/her to do so have been taken without success.

3. A person is not to be treated as unable to make a decision merely because he/she makes 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 his/her best interests.

5. Before the act is done, or 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.

This form has been developed to aide practitioners to assess and document a person's mental capacity giving due regard to the Mental Capacity Act 2005.

Day to day interventions and decisions can be recorded in the person's care plan/notes e.g. personal hygiene care, feeding a patient etc, and assessments of capacity in respect of such decisions should be reviewed. If a practitioner proposes health or social care treatment, they must assess the person's capacity to consent. This can involve the multi-disciplinary team, but ultimately it is up to the practitioner responsible for the person's treatment to make sure that the person's mental capacity has been assessed. No one can give consent on behalf of a person who lacks capacity to make the **decision for himself/herself.**

Using a different form: Mental Capacity Assessment – for complex decisions

When the decision to be made, is more complex or could have serious consequences for the person, careful consideration about the level of assessment, and who should be involved, will be required. More formal assessments might be required in complex cases or cases where mental capacity or the decision to be made is disputed. However, the final decision about a person's mental capacity must be made by the person intending to make the decision or carry out the action on behalf of the person who lacks mental capacity. In an urgent or emergency situation, a decision may be made in the person's best interests to give urgent treatment or care without delay - except when the healthcare professional giving treatment is satisfied that an Advance Decision to refuse that treatment exists; or an Attorney or Deputy with relevant authority exists. If it has been established that the person lacks mental capacity for the required decision, the Decision Maker should now consider what would be in the person's best interests.

Form 1 - Mental Capacity Assessment (MCA)

This form has been developed to support compliance with the Mental Capacity Act 2005.
There is a statutory requirement for anyone undertaking an assessment to have regard to the Code of Practice for the Mental Capacity Act. References given below refer to the relevant paragraphs of the Mental Capacity Act Code of Practice. Please also refer to RMT Policy and Guidance.

1.1 Person's details

Name: **Date of Birth:**

Case/Ref/NHS number:

Present Address/Location:

Home Address (if Different):

1.2 What is the specific decision relevant to this mental capacity assessment? Please ensure that the decision is phrased in a way to enable all viable options to be discussed. The MCA Code paragraph 4.4 states 'An assessment of a person's capacity must be based on their ability to make a specific decision at the time it needs to be made, and not their ability to make decisions in general.'

Details:

1.3 Person undertaking/or who has undertaken this assessment of capacity? The person with greatest responsibility for the specific decision is known as the 'decision-maker' and should assess capacity. The decision maker is the person intending to make the decision or carry out the action. Complex decisions may require specialist assessment - seek guidance. See 4.38 to 4.43 of the Code.

Name: **Role:**

Organisation: **Address:**

Tel: **Email:**

Date and time of assessment:

1.4 What concerns/triggers have given rise to this assessment of capacity? People have the right to make decisions that others might think are unwise. A person who makes a decision that others think is unwise should not automatically be labelled as lacking the capacity to make a decision. See MCA Code 4.35.

What is the reason to believe this person may lack capacity to make this particular decision? State your evidence:

1.5 Record your evidence here of the actions you have taken to support the person. Consider what kind of help and support you can give the person to help them understand, retain, weigh up information and communicate their decision.

Have you discussed with the person and/or appropriate others the most suitable venue for the assessment? For example: Does the person feel more comfortable in their own room? Does it need to be quiet? See MCA Code 3.13.

Have you discussed with the person and/or appropriate others to establish timing of assessment? For example: Is there a time of day that is better for the person? Would it help to have a particular person present? See MCA Code 3.14.

Does the person have any language/communication issues? For example: Do they have hearing or speech difficulties? Do you need an interpreter? Do they communicate using special equipment e.g. a light talker communication device? See MCA Code 3.11.

Have you provided all the information, regarding all viable and available options that the person needs to consider, to make an informed decision? See MCA Code 3.7. The assessor must ensure that the person has:

- **a)** Sufficiently detailed alternative plans explained to them to allow them to weigh up the alternatives and make an informed choice where possible.
- **b)** Been supported by the assessor to explore the reasonably foreseeable consequences of deciding one way or another, or failing to make the decision.

Describe:

Viable options considered:

If the decision is not urgent can it be delayed because the person is likely to regain or develop the capacity to make it for themselves?

☐ The decision can be delayed

☐ Not appropriate to delay the decision

☐ Person not likely to gain or develop capacity

Explain why you have ticked box(s):

1.6 Two Stage Capacity Assessment. Answer the question with facts. The questions cannot be answered with a simple "yes" or "no" and you are asked to describe the assessment process. See MCA Code Ch. 4.

Stage 1. Is there an impairment or disturbance in the functioning of the person's mind or brain? The person may not have a diagnosis but the Code says that proof of an impairment or disturbance of the functioning of the mind or brain is required. You should record here your reasons for believing this to be the case. See 4.11 - 4.12 of the Code. This could be because of, for example, a head injury, a suspected infection or stroke, a diagnosed dementia, mental illness, or learning disability.

Yes ☐ **No** ☐

Describe:

If the person does not meet Stage 1, the assessment should immediately stop.

Stage 2. Record here how the identified impairment or disturbance in Stage 1 is affecting the person's ability to make the decision. See 4.13 to 4.30 of the Code.

Can the person understand the information relevant to the decision? See 4.16 to 4.19 of the Code.

Yes ☐ **No** ☐

Describe how you assessed this:

Can they retain that information long enough to make the decision? See 4.20 to 4.22 of the Code.

Yes ☐ **No** ☐

Describe how you assessed this:

Can they use or weigh up that information as part of the process of making the decision? See 4.21 to 4.22 of the Code.

Yes ☐ **No** ☐

Describe how you assessed this:

Can they communicate their decision, by any means available to them? See 4.23 to 4.25 of the Code.

Yes ☐ **No** ☐

Describe the reasons for your conclusion:

NB. If all of the answers to the four questions above are YES, then Stage 2 is not met and the assessment must end.

Stage 3: Causative Nexus

There is a causative link between the impairment or disturbance in the functioning of mind and brain AND the inability to make the required decision. You must be able to evidence that the reason the person is unable to make the decision is **because of** the impairment or disturbance in the functioning of mind or brain and for no other reason.

Yes, there is a causative link ☐

No, there is not a causative link, so the person has capacity to make the relevant decision. The decision may therefore be an unwise decision. ☐

Evidence:

1.7 Lack of mental capacity as a result of an impairment/disturbance in mind/brain must be distinguished from a situation where a person is unable **to make their own decision as a result of duress or undue influence**. A person who has the mental capacity to make decisions may have their ability to give free and true consent impaired if they are under constraint, coercion or undue influence. Duress and undue influence may be affected by eroded confidence due to fear of reprisal or abandonment, sense of obligation, cultural factors, power relationships or coercive control within domestic abuse. Do you have a concern that the person may be under duress/coercion or undue influence in relation to the making of this decision? If so, this will not satisfy the Stage 1 (Diagnostic) test. You have to have an impairment or disturbance of the mind or brain to satisfy that test.

Do you have a concern that the person may be under duress, coercion or undue influence?

Yes ☐ **No ☐**

If yes, what is your evidence for saying this?

If yes, what actions you intend to take (including consideration of seeking management/legal advice):

1.8 Please record here any further information or content of your interview with the person.

1.9 Determination of Capacity

I have assessed this person's capacity to make the specific decision and determined on the balance of probability that they **do not have the capacity** to make this decision at this time**.**

Name: **Signature:**

Date:

I have assessed this person's capacity to make the specific decision and determined that on the balance of probability that they **have the capacity** to make this decision at this time.

Name: **Signature:**

Date:

1.10 If you have been supported to carry out the capacity assessment by another person or professional, please give their details here and state if they agree with the decision you have reached about the person's capacity?

Name	Role/Relationship	Indicate Yes/No	Address	Signature

Describe reasons for any difference of opinion and intended action:

1.11 Who is the Decision Maker? The decision maker will be the person or professional who is responsible for making the decision you have identified, or undertaking the action on behalf of the person, if it is established that they lack capacity, unless there is a valid and applicable Enduring Power of Attorney, Lasting Power of Attorney or Court Appointed Deputy. In this case, the Attorney or Deputy will be the decision-maker for the decision if it is within the scope of their authority. See 5.8 of the Code. (chapter 7, 8)

Is there an Enduring Power of Attorney (EPA) under previous legislation? **Yes** ☐ **No** ☐

EPAs only cover property and finance and not personal welfare decisions or Continuing Health Care decisions. EPAs have been replaced by Lasting Powers of Attorney. They can still be used if they were made and signed before October 2007. The EPA must be registered with the Office of the Public Guardian if the donor is losing, or has lost the capacity to make property and financial decisions.

Is there a registered Property & Affairs Lasting Power of Attorney? **Yes** ☐ **No** ☐

This covers property and finance and not personal welfare or Continuing Health Care decisions.
An LPA cannot be used until it has been **registered** by the Office of the Public Guardian and confirmation of authority has been verified. Once registered it can be used both before and after the donor loses capacity.

Is there a registered Personal Welfare Lasting Power of Attorney? **Yes** ☐ **No** ☐

This covers personal welfare decisions, which includes Continuing Health Care decisions.
An LPA cannot be used until it has been registered by the Office of the Public Guardian. Unlike an LPA for finances, a welfare LPA can only be used once the donor has lost capacity.

Is there a Court Appointed Deputy for Property and Affairs? **Yes** ☐ **No** ☐

This covers property and finance and not personal welfare or Continuing Health Care decisions.

Is there a Court Appointed Deputy for Health and Welfare? **Yes** ☐ **No** ☐

This covers personal welfare decisions, which includes Continuing Health Care decisions.

Does the Attorney/Deputy have the authority to make this decision? **Yes** ☐ **No** ☐

You must check the paperwork to verify that the authority of the Attorney or Deputy has not been restricted by the person or the Court of Protection; that it covers this decision and is valid and applicable. Also consider if the person has an advance decision to refuse treatment. In the absence of verification, you can contact the Office of the Public Guardian who will confirm if there is an existing EPA / LPA / Deputy.

Give details and verify that you have seen the original:

Contact details of named Attorney/Deputy:

Record here any unsuccessful attempts to contact Attorney/Deputy, or if you have been unable to verify existence of these powers at the time of assessment:

The Mental Capacity Act 2005 (MCA) Section 5 provides you with protection from liability if you act in the best interest in connection with the person's care or treatment regarding actions you take at a time when the person lacks capacity to make a decision regarding the particular decision required.

Clearly identify who is the named decision maker for this decision if the person is assessed as lacking capacity.

Name:	**Role:**
Organisation:	**Address:**
Tel:	**Email:**

1.12 Does the person require an IMCA?

- If the person (16+) is unbefriended and the decision is about a change of accommodation, or serious medical treatment, you MUST involve an IMCA. **It is not anticipated that RMT staff will be involved in assessing capacity regarding decisions relating to change of accommodation or serious medical treatment**
- If a friend or family member exists, but they may not act in the person's best interests (for example because they are the alleged victim or abuser in a Safeguarding Adults investigation) you MAY involve an IMCA.
- If the person is unbefriended and a health or social care review is being carried out, you MAY CONSIDER involving an IMCA as good practice.
- Although you may involve an IMCA under the Mental Capacity Act legislation, if there is no appropriate person, for people over age 18, you MUST instruct a Care Act Advocate if the person has substantial difficulty engaging with the relevant assessment & support planning/review/safeguarding process. Please use the most appropriate legislation to ensure entitlement to advocacy.

Yes ☐ **No** ☐

If not please give reasons:

Date of referral to the IMCA service:

NB. What to do now having completed Form 1 - Mental Capacity Assessment:

- **If the person requires an IMCA please make an IMCA referral by contacting the relevant Local Authority in the area where P is a resident.**
- **If it is concluded that the person does not have capacity and the decision cannot be delayed, the decision maker will proceed to make a best interests decision. This should be recorded on the Best Interests Decision Form.**

Form 2 - Best Interests Decision (MCA2)

There is a statutory requirement for anyone undertaking an assessment to have regard to the Code of Practice for the Mental Capacity Act. Where a person lacks capacity to validly consent, a decision MUST be made in their best interests. References given below refer to the relevant paragraphs of the MCA Code.
What is the Best Interests Principle and who does it apply to? The Best Interests Principle is set out in the MCA (2005). The MCA Code of Practice (s.5) states '*Any act done or decision made for or on behalf of a person who lacks capacity must be done or made in their best interests*'. Best Interests includes medical, social, personal and financial best interests. Certain decisions such as consenting to sexual relations, divorce, marriage/civil partnership or adoption are excluded. Please consult the Statutory Care & Support Guidance and the MCA Code of Practice.

3.1. Person's details	
Name:	**Date of Birth:**
Case/Ref/NHS number:	
Present Address/Location:	
Home Address (if Different):	

3.2 Views of relevant/interested parties. Prior to making a decision in a person's best interests, the decision maker must take into account the views of others. The views of each party MUST be recorded. It is appropriate to hold a best interests meeting where the decisions facing the person are complex and cannot be easily made by the decision-maker or where there are differing opinions about what outcome is in a person's best interests. **Please name each individual consulted and give date when consultation took place.**
Present and Past views, wishes, feelings, beliefs and values of the person – as far as they are able to express them, including any relevant advance decision or advance directive
Views of parents (if under 18) /partner/spouse
Views of family (Note there may be differing views held by family members and conflicts of interest. All should be taken into account)
Views of any advocate or IMCA
Views of any donee of Lasting Power of Attorney or Court of Protection Deputy – note the type of LPA/CoPD will be relevant **Views of any other relevant party (Please state whose views are being recorded)**
Any other relevant factors to be considered, or which the person would like to be considered

3.3. Outcome of Best Interests Decision This decision is made by the decision maker, having taken into account the views of all relevant parties and considered what is the least restrictive option. *Please describe how the decision has been reached through balance sheet approach and what weight was attached to various factors. A balance sheet considers all the views of all relevant parties regarding the options, the pros and cons and the weight attached to each and why.*
Details: **Options 1:** **Pros:** **Cons:** **Option 2:** **Pros:** **Cons:** **Evidence and reason for the best interest decision:**

3.5 Details of the Best Interests Decision Maker	
Name:	**Address:**
Role:	**Email:**
Organisation:	**Tel:**
Date of assessment decision:	**Signature:**