WORKING WITH THE MENTAL CAPACITY ACT 2005

Third Edition

SAMPLE PAGES

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Mental Capacity Act 2005

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Consent

'Every adult capable of making decisions has an absolute right to accept or refuse medical treatment, regardless of the wisdom or consequences of the decision. The decision does not have to be justified to anyone. Without consent any invasion of the body, however well-meaning or therapeutic, will be criminal assault.'

Court of Protection: Wye Valley NHS Trust v Mr B [2015] EWCOP 60

The Mental Capacity Act

'The Mental Capacity Act 2005 established a comprehensive scheme for decision-making on behalf of people who are unable to make the decision for themselves. The decision-maker - whether a carer, donee of a power of attorney, court-appointed deputy or the court - stands in the shoes of the person who is unable to make the decision - known as P - and makes the decision for him. The decision has to be that which is in the best interests of P.'

Supreme Court: N v ACCG & Ors [2017] UKSC 22

How many people?

'At any one time, an estimated 2 million people in England may lack the mental capacity to make decisions about their care and treatment. In the MCA we have legislation that stresses the importance of person-centred care.'

Alistair Burt, Minister of State for Community and Social Care, 8 October 2015

Using the Act

'As I have said, the Mental Capacity Act does not impose impossible demands on those who do acts in connection with the care or treatment of others. It requires no more than what is reasonable, practicable and appropriate.'

Court of Appeal: ZH v the Commissioner of Police for the Metropolis [2013] EWCA Civ 69

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INTRODUCTION

This third edition of *Working with the Mental Capacity Act 2005* updates the last edition with an extensive series of amendments and additions to provide an up-to-date and comprehensive guide to the legislation. For those familiar with the previous edition, the following changes have been made:

- Every chapter has been reviewed and updated to include the latest case law and guidance available at the time of writing.
- A series of new chapters have been added, including:
  - consent to care and treatment and its relationship to the Act
  - the inherent jurisdiction
  - tenancy agreements and the Act
  - testamentary capacity – making a will
- Another new chapter called *Decisions Decisions* considers case law around particular decisions and provides guidance for health and social care staff around:
  - sexual relations
  - contraception
  - contact with others
  - marriage
  - admission for care
  - religious practices – fasting and personal grooming
  - end of life
  - do not attempt cardiopulmonary resuscitation (DNACPR)
  - covert medication
- Codes of Practice – more detailed and referenced quotes from the Codes are included in each chapter.
- Questions – frequently asked questions and answers based on the authors' experiences as trainers to health and social care staff are included throughout the book.
- Diagrams, charts and tables – new and updated diagrams and tables are used to help explain various parts of the legislation.
- Case law – a substantial amount of new case law related to the Act is directly integrated into the text.
- Summary sheets – at the beginning of key chapters at a glance summaries of key points are provided.

Steven Richards and Aasya F Mughal
April 2018

PROTECTION, POWERS, DEFENCE AND DUTIES

'The Mental Capacity Act 2005 established a comprehensive scheme for decision-making on behalf of people who are unable to make the decision for themselves. The decision-maker - whether a carer, donee of a power of attorney, court-appointed deputy or the court - stands in the shoes of the person who is unable to make the decision - known as P - and makes the decision for him. The decision has to be that which is in the best interests of P.'

Supreme Court judgment, N v ACCG & Ors [2017] UKSC 22

The Mental Capacity Act 2005 provides a statutory framework for assessing whether a person has mental capacity to make certain decisions. It also defines how others can make decisions on behalf of those who lack mental capacity to decide for themselves. Its scope is wide-ranging, involving decisions regarding healthcare, social care and financial affairs. The Act directly addresses the issue of providing care and treatment for people who lack the mental capacity to consent to it.

Prior to the legislation being introduced, such decisions lacked legal protection unless they followed the common law rules relating to mental capacity and best interests. These common law rules were derived from previous cases that had been to court in which judges had set out how mental capacity should be assessed and given guidance in relation to making best interest decisions. However, many health and social care staff were unaware of these court cases governing assessments of mental capacity and best interests decision-making. This resulted in assessments with no basis in law and consequently no legal protection for staff or the individuals they assessed. It was not uncommon for assessments of mental capacity to be unlawful because they were based solely on a person's diagnosis, for example a doctor might decide that someone lacked mental capacity just because they had dementia. Other assessments had been based solely on inappropriate testing, such as psychiatric assessments establishing a mental health diagnosis, a mini mental state examination or an IQ test where low results were seen to equate to a lack of mental capacity. Although these were important tests for different purposes, for example obtaining a diagnosis, they were unlawful ways to assess mental capacity.

The Act resolved this problem by clearly defining how to assess mental capacity and best interests. The legislation can be seen as working in a number of ways – providing protection, a defence, powers and duties.

Protection

The Act provides protection for people whose mental capacity is called into question. As indicated above, it was not uncommon prior to the introduction of the legislation for people to be labelled as lacking mental capacity to make decisions based purely on their diagnosis, such as dementia. For these people, the Act provides protection by asserting that regardless of a person's diagnosis or behaviour, they must be assumed to have mental capacity. Any doubt over a person's mental capacity must be proven by following the assessment laid down in the legislation and evidencing the reason they lack mental capacity. The person being assessed has to prove nothing.

For people lawfully assessed as lacking capacity, the legislation provides protection by setting out a mandatory procedure for making decisions on their behalf (best interest decisions). The procedure takes into account the wishes and values of the person and those closest to them and involves the person in the decision-making as far as possible. Because of this approach, the decision arrived at may not necessarily be in the person's best *medical* interests or the safest option available but will be respectful of them as an individual and their human rights. The importance of the Act was underlined in 2015 by Lord Faulks, Minister of State (Ministry of Justice) during a House of Lords debate. Referring to the terrible abuse of learning disabled adults at the Winterbourne View private hospital, Lord Faulks stated:

'… the failings at Winterbourne View were completely unacceptable and use of the Mental Capacity Act there was poor, if not non-existent. The Government strongly believe that better

CURRENT CHALLENGES IN PRACTICE

The Act celebrated its tenth year in October 2017. However, despite the great benefits the legislation offers to individuals and professionals (see chapter *Protection, Powers, Defence and Duties)* a major concern remains that the core elements of the Act are not being applied effectively or consistently across health and social care services.

Care Quality Commission

A report by the Care Quality Commission (CQC), *The state of care in NHS acute hospitals: 2014 to 2016*, published in March 2017 stated:

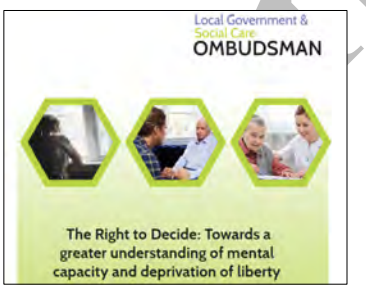
> *'Understanding about the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, and in turn seeking patients' consent to treatment, is another area where many hospitals struggle to perform well. Often acute hospitals do not properly understand the legislation or how to apply the provisions of the Act.'*

In October 2017, the CQC's most recent report, *The state of health care and adult social care in England 2016/17* noted:

> *'Capacity is an important area where providers and staff often seemed to lack understanding. There was often not enough time spent assessing a person's changing capacity. In acute hospitals, adult social care and mental health services, inspectors felt staff needed to be more aware of the importance of assessing different areas of a person's capacity, and the fact that these can fluctuate on a daily basis.'*

Both reports are available from: *www.cqc.org.uk*

Local Government and Social Care Ombudsman



In July 2017 the Local Government and Social Care Ombudsman produced a report called *The Right to Decide: Towards a greater understanding of mental capacity and deprivation of liberty.* It was triggered by the fact that approximately 20% of all complaints to the Ombudsman are now mental capacity or Deprivation of Liberty Safeguards related and 69% of these cases were upheld (fault found) which is much higher than the average for other ombudsman complaints. The Ombudsman noted:

> *'This report looks at the common issues we see from our investigations when a council or care provider is involved with a person who lacks mental capacity. These include failures to carry out assessments to ascertain whether someone has capacity to make decisions; poor decision making when deciding on someone's best interests; and not appropriately involving families and friends in the process.'* The report is available from *www.lgo.org.uk*

CONSENT AND THE MENTAL CAPACITY ACT

The legal foundation and starting point for the majority of health and social care decisions for adults, is their consent. Understanding the connection between consent and the Mental Capacity Act (the Act) is vital for staff working with adults in any care setting. In the case of *Wye Valley NHS Trust v Mr B [2015] EWCOP 60,* the judge summarising a Supreme Court ruling, stated:

> *'Every adult capable of making decisions has an absolute right to accept or refuse medical treatment, regardless of the wisdom or consequences of the decision. The decision does not have to be justified to anyone. Without consent any invasion of the body, however well-meaning or therapeutic, will be criminal assault.'*

In the case of *Montgomery v Lanarkshire Health Board [2015] UKSC 11* the Supreme Court stated:

> *'An adult person of sound mind is entitled to decide which, if any, of the available forms of treatment to undergo, and her consent must be obtained before treatment interfering with her bodily integrity is undertaken.'*

A person with mental capacity can therefore refuse any treatment including life-saving treatment. This was the case in *King's College Hospital NHS Foundation Trust v C and V [2015] EWCOP 80* where a woman receiving dialysis treatment decided she wanted it to stop. The consequences of refusing further dialysis was relatively imminent death. Doctors questioned whether she had the mental capacity to make the decision (to refuse treatment). The judge found she did have mental capacity as she understood and accepted the consequences of her decision and was therefore able to refuse consent to further treatment. The judge stated:

> *'A capacitous individual is entitled to decide whether or not to accept medical treatment. The right to refuse treatment extends to declining treatment that would, if administered, save the life of the patient.'*

In response to the Supreme Court ruling of *Montgomery* above, the Royal College of Surgeons revised their professional guidance in 2016 *(Consent: Supported Decision-Making).* It notes:

> *'Patients have a fundamental legal and ethical right to decide what happens to their bodies. It is therefore essential that patients have given valid consent for all treatments and investigations.'*
>
> *'Touching another person without permission is the definition of battery, so the patient's consent is a necessary step prior to starting any treatment.'*

The guidance is available from: *www.rcseng.ac.uk*

The Nursing and Midwifery Council's *The Code: Professional standards of practice and behaviour for nurses and midwives (www.nmc.org.uk)* states:

> *'4.2 make sure that you get properly informed consent and document it before carrying out any action.'*

It should be noted that the legal requirement to obtain consent applies to anyone working with adults including social workers.

Informed consent

For a person to consent, they must be given information relevant to the decision and their agreement must be freely obtained (they cannot be coerced). This is often called informed consent. The information that needs to be given to the person is three-fold:

1. *Nature* – what is going to happen?
2. *Purpose* – why is it necessary?
3. *Consequences* – the risks/consequences/outcomes of giving consent or refusing.

USING THE ACT IN PRACTICE

For health and social care staff, the Act, and indeed this book, can be distilled into the following chart in terms of applying the legislation in daily practice. Although the Act is wide ranging in its application, it is essentially very simple to use in day-to-day practice.

Consent

A person understands the *nature* (what) + *purpose* (why) + *consequences* (risks) of a health or social care intervention or action and they are not coerced (consent is freely given).

When a person cannot consent, the Mental Capacity Act can be applied
(aged 16+ with an impairment of, or disturbance in the functioning of, the mind or brain)

Mental capacity assessment

The Act is founded on the concept of whether people have mental capacity to make their own decisions. At any one time, approximately two million people may lack mental capacity in England and Wales.

- A mental capacity assessment is time and decision specific.
- To have mental capacity a person must, at a specific time and for a specific decision, be able to do all of the following:

  1. understand 2. retain 3. use or weigh 4. communicate a decision
- If they cannot do one of the above points *because of* an impairment of, or disturbance in the functioning of, the mind or brain they would be assessed as lacking mental capacity for that specific decision, at that time.

Best interests decision

If a person lacks mental capacity nothing can be done to or for them unless it is in their best interests. Best interests under the Act means consideration of a statutory checklist of items which includes:

the relevant circumstances + current and prior wishes, statements and feelings of the person + beliefs and values of the person + consulting people who know the person + less restrictive options in delivering care + the person's participation + considering whether the person is likely to regain capacity.

For the majority of people who lack capacity to consent, the two assessments above are all that will be needed under the Act (mental capacity assessment and best interests).

Restraint

A number of people who lack mental capacity to consent to care or treatment will, in addition, need some element of restraint to keep them safe. The Act defines restraint as: the use or threat of force to make a person do something they resist *or* the restriction of liberty of movement whether or not the person resists. Whilst the term restraint can sound negative, sometimes it is essential when caring for people in their best interests.

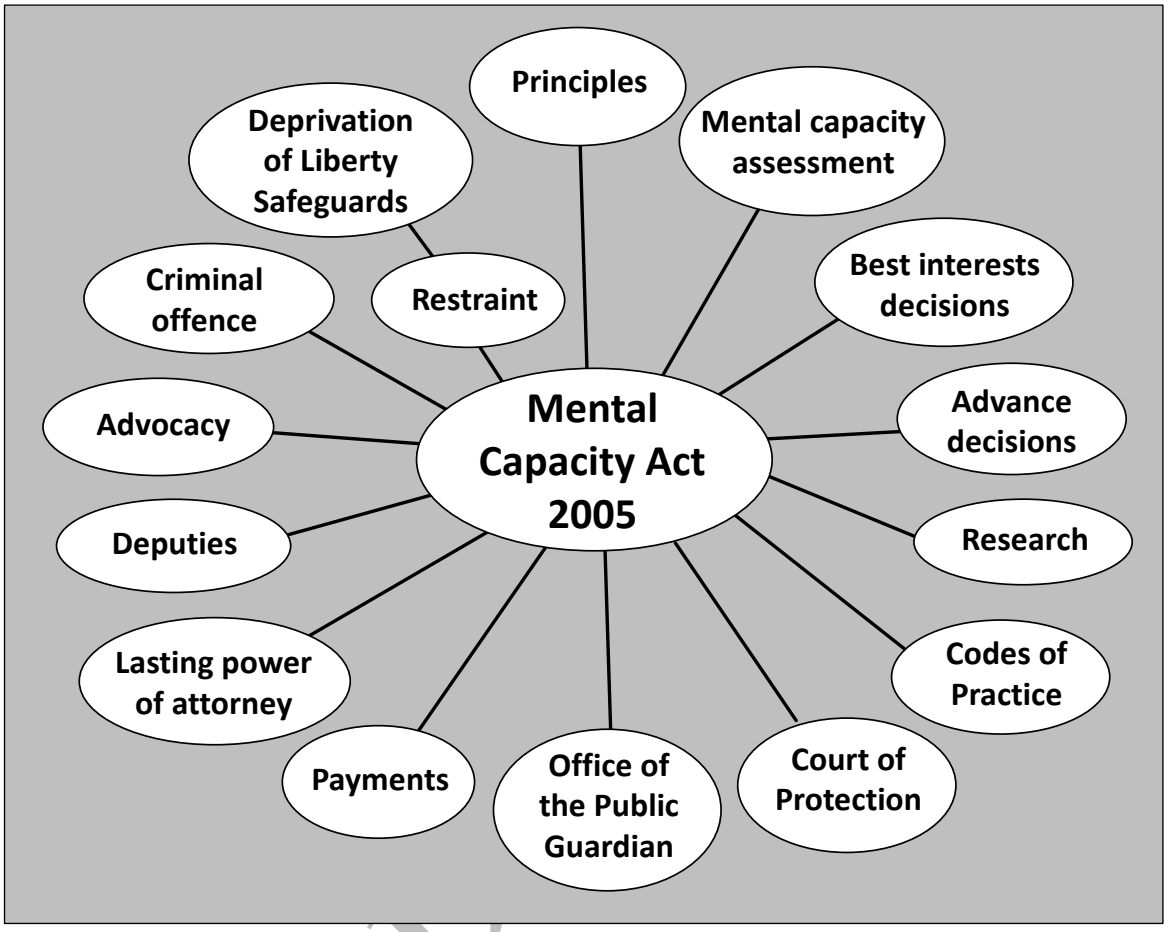
Criteria for use: a person lacks capacity about the proposed act + the proposed act is in their best interests + the restraint is to prevent harm to them + the restraint is a proportionate response to the risk and likelihood of harm.

Deprivation of Liberty Safeguards (DoLS)

To protect some people who lack mental capacity from coming to harm, the duration and level of restraint necessary will mean they are deprived of their liberty. The Mental Capacity Act has more than one way to authorise a deprivation of liberty. DoLS covers people aged 18 and over in care homes or hospitals and the Court of Protection can authorise deprivation of liberty in other locations such as supported living or even a person's own home. Official figures indicate over 66,000 people in care homes and hospitals in England were under DoLS on 31 March 2017.

KEY PARTS OF THE ACT

The Act contains several key parts listed below. Each one has a dedicated chapter in this book.



- **Principles** – five principles that underpin the entire Act and provide a safeguard for people whose mental capacity is called into question.
- **Mental capacity assessment** – a standard assessment to check whether a person can make a specific decision at a specific time.
- **Best interests decisions** – a procedure for others to make decisions on behalf of people who lack mental capacity concerning their care, treatment and/or finances.
- **Advance decisions to refuse treatment** – allows people with mental capacity to plan ahead and refuse future treatment if they later lose capacity.
- **Research** – powers and procedures that allow for and safeguard research conducted with people who lack capacity.
- **Codes of Practice** – two statutory codes; one covers the Act and a further supplementary code, covers the Deprivation of Liberty Safeguards.
- **Court of Protection** – the court acts as the main arbitrator on disputed and complex decisions concerning the Act.
- **Office of the Public Guardian** (OPG) – primarily registers and monitors lasting powers of attorney and deputies.

Mental Capacity Assessment: What? Why? How?	
What?	An assessment that considers whether a person has the mental capacity to make a decision around healthcare, social care or finances.
Why?	When a person is not able to give or refuse consent to care or treatment or make other decisions, the assessment of capacity provides the gateway to using the Mental Capacity Act and making a decision in the person's best interests.
How?	It can be carried out anywhere in England and Wales and is a standard four stage assessment.
Legal criteria	▪ the person being assessed is aged 16 or over and has an impairment of or disturbance in the functioning of the mind or brain. ▪ the mental capacity assessment is time and decision specific. ▪ To have mental capacity a person must be able to understand information relevant to the decision + retain that information during the decision-making process + use or weigh the information + communicate a decision. ▪ The person carrying out the assessment is obliged to take 'practicable steps' to help the person during the process. ▪ If a person can do all four points above, they have mental capacity and can give or refuse consent to care or treatment (or other decisions). ▪ If however, a person cannot do one or more of the items in the four stage assessment and this is *because of* an impairment or disturbance in the functioning of the mind or brain, they lack mental capacity to make that decision, at that time. ▪ If they do lack mental capacity, then anything done to or for them must be in their best interests (see chapter *Best Interests Decisions).*
Who is involved?	Anyone can assess capacity. The person with authority for a particular decision should carry out the assessment. For example: ▪ To prescribe medication the assessment should be carried out by the prescriber. ▪ To move a person into a care home would need a social worker to assess capacity (where the local authority is funding the placement). ▪ For surgery it should be the surgeon undertaking the operation who assesses mental capacity.
Limits	The mental capacity assessment applies to decisions around health, finances and social care. Other decisions such as the capacity to make a will (testamentary capacity) are covered by other law.
Practice points	Before assessing mental capacity, the assessor must identify the relevant information a person needs to understand for that specific decision. The information presented needs to cover the salient factors and should be provided in a format appropriate to the person (for example simple language, visual aids).
Law and Code	Section 2 and 3 of the Act and chapter 4 of the Code of Practice cover the mental capacity assessment.

MENTAL CAPACITY ASSESSMENT

The ability to make decisions lies at the heart of the Act. The Code of Practice (para 4.1) notes:

> *'Mental capacity is the ability to make a decision. This includes the ability to make a decision that affects daily life – such as when to get up, what to wear or whether to go to the doctor when feeling ill – as well as more serious or significant decisions.'*

The Act defines mental incapacity and then provides a method to assess it. The assessment is central to the operation of the Act. If a person is assessed as lacking mental capacity, many of the other powers within the Act can be accessed, such as making a best interests decision on the person's behalf. However, if a person is found to have mental capacity, they retain power over their own decision-making. Accordingly, ensuring the assessment is lawful and clearly recorded is fundamental to ensure a person's legal rights to make their own decisions, whenever possible, are protected. It is important to note that the assessment is time and decision specific so that finding a person lacks capacity does not mean they lack capacity to make all decisions permanently. For many people, an assessment that they lack capacity may only be temporary and about a single decision, for example a person may lack capacity to consent to personal care whilst they are confused due to an infection.

The assessment is a 'functional' one which looks at the decision-making process rather than the outcome, that is, the reasoning process rather than the decision made. The legislation (section 2(3)) clearly states that a lack of mental capacity cannot be decided merely by reference to a person's age, appearance, condition or behaviour. The Code of Practice (para 4.8) notes:

> '... *the physical characteristics of certain conditions (for example, scars, features linked to Down's syndrome or muscle spasms caused by cerebral palsy) as well as aspects of appearance like skin colour, tattoos and body piercings, or the way people dress (including religious dress).*'

For example, someone who has an established learning disability with severe behavioural problems does not necessarily lack capacity. The learning disability would provide evidence of an impairment of, or disturbance in the functioning of, the mind or brain required by the Act but a mental capacity assessment would be necessary to establish whether the person lacked the mental capacity to make a particular decision *because of* their learning disability.

In the case of *Re SL [2017] EWCOP 5* a judge highlighted the gravity of assessing mental capacity:

> *'A decision about capacity is significant. A finding that a person lacks capacity in relation to a specific matter means that she is deprived of the right to make decisions for herself. That is something which adults in the general population take for granted. It is a significant interference in a person's right to self-determination.'*

Note: an assessment of capacity is different to, and cannot be judged or decided by, a mini mental state exam (MMSE), a dementia assessment or an intelligence quotient (IQ) assessment. These assessments can be used to provide evidence of an impairment of, or a disturbance in the functioning of, the mind or brain but they do not constitute an assessment of mental capacity which is defined in the Act.

Law and Code of Practice

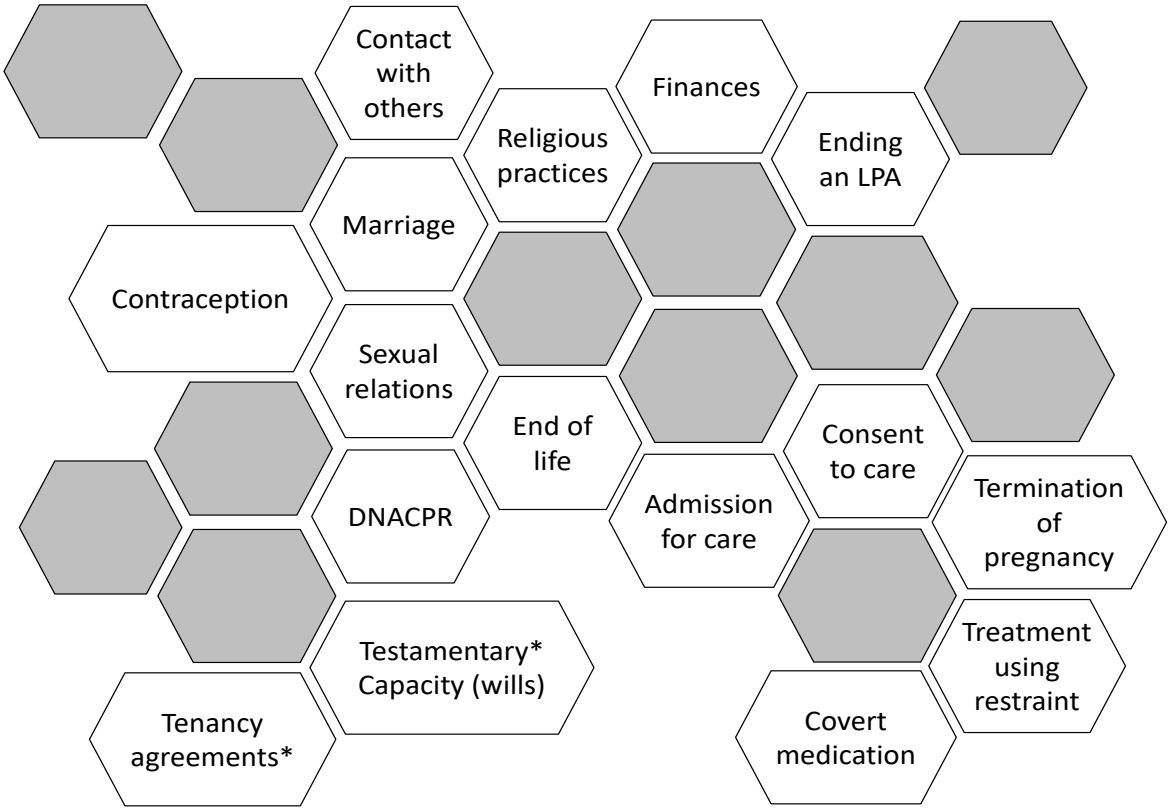
The definition and assessment of mental capacity are contained in sections 2 and 3 of the Act and chapter 4 of the Code of Practice provides further guidance.

The starting point

Before the assessment can be undertaken, the following criteria must be met:

1. **Age:** the person being assessed is at least 16 years old (for some financial decisions the person can be under 16 however). See chapter *Age Exceptions.*

DECISIONS DECISIONS



This chapter looks at how the courts have approached mental capacity assessments or best interests assessments in relation to a variety of decisions. It is broken down into two parts. The first part considers what the courts have said in relation to assessing mental capacity for these decisions, specifically what information the assessor needs to present to the person and equally the information the person needs to understand. The second part of the chapter provides examples of best interests decisions made by the courts and how they have approached their decision-making.

* In addition to the cases in this chapter there are separate dedicated chapters on *Testamentary Capacity (Wills)* and *Tenancy Agreements* later in this book.

Part One

Assessing mental capacity – what information does a person need to understand?

The Code of Practice (para 4.16) states:

> *'It is important not to assess someone's understanding before they have been given the relevant information about a decision … Relevant information includes: the nature of the decision, the reason why the decision is needed, and the likely effects of deciding one way or another, or making no decision at all.'*

Depending on the decision to be made, the relevant information changes. How does an assessor know what relevant information they should present to the person they assess? As case law in this field has developed, judges have explored what they consider to be the relevant information to make various decisions.

In the case of *London Borough of Tower Hamlets v TB and SA [2014] EWCOP 53* the judge stated that whilst they had to follow the statute (sections 1 to 3 of the Act) when deciding if a person had mental capacity to consent to sexual relations, this was not the complete picture:

'*… the statutory provisions and the language of the statute tell me nothing about what is "the relevant information" when wrestling with the thorny question of sexual capacity. It is therefore necessary to look with some care at the decided cases.'*

A number of these *decided cases* are detailed below. Whilst not all of these can provide an absolute precedent, we suggest that assessors should follow them as a guide because they provide the information that should be given to the person being assessed and which the person then needs to understand, retain and use or weigh. Finally, a useful description when assessing mental capacity was given by a judge in the case of *Derbyshire County Council v AC & Ors [2014] EWCOP 38:*

'I have been careful not to set the test of capacity too high, lest it operate as an unfair, unnecessary and indeed discriminatory bar against the mentally disabled. I have also borne in mind that the question of capacity is 'decision-specific'. I have had to consider whether AC has been able to consider the necessary information, if not all the peripheral detail; I recognise that different individuals may give different weight to different factors.'

Contact with others

Case law about whether a person has mental capacity to have contact with other people is normally about protecting people who lack mental capacity from abusive relationships. It commonly originates in safeguarding adults procedures reaching a level where a court order is needed to control or ultimately prevent contact between a vulnerable incapacitated adult and another person (see chapter *Safeguarding Adults and the Mental Capacity Act)*. If a person lacks mental capacity and services such as a local authority have concerns about their contact with another person, the authority should approach the court for an order about contact. There is a considerable amount of case law in this area.

The case of *LBX v K, L, M [2013] EWHC 3230 (Fam)* was about L. One of the issues was whether L had the mental capacity to consent to contact with others and, in particular, his father. The judge broke down the relevant information that L would have to understand, retain and use or weigh to consent to contact. Based on the judge's comments, the summary below may be used as guidance in other cases:

1. The nature of the relationship with the person he is to have contact with.
2. What sort of contact he could have with the person. This includes different locations, durations and arrangements such as the presence of a support worker.
3. The positive and negative aspects of having contact with each person based on his own evaluations. Such evaluations will only be irrelevant if they are based on false beliefs. For example, if a person believed that an individual they might have contact with had assaulted them when they had not.
4. Past positive and negative experiences.

The case highlighted the need to support a person to remember the positive aspects of contact with someone (in this case L's father) and not just focus on the negative aspects. Assessor's records should show they have assessed the person in a fair and balanced way and have not led the person, for example, to focus only on negative consequences in relation to contact.

In the same case, the judge considered that the following information was not relevant:

'*… abstract notions, like the nature of friendship and the importance of family ties … the long-term possible effects of contact decisions … and risks which are not in issue …'*

Professionals should ensure therefore, that hypothetical risks that have no evidential basis are not added into the assessment process so the person being assessed is able to focus on the real points that form the key information relevant to their decision-making.

The same case about L went back to court in 2016 *(Re L: K v LBX [2016] EWHC 2607)* because L's father made an application to have contact with his son. He disputed the results of his son's mental capacity assessments and criticised the professionals involved. The application was rejected because the court confirmed that L still had mental capacity. The judge referred to good quality witness evidence which she summarised and might be helpful for other assessors to read:

ADVANCE DECISIONS TO REFUSE TREATMENT (ADRT)

The terms *advance directive* and *living will* are reasonably well known. The Act introduced a new term *advance decision* and provides a clear statutory procedure for making such decisions. An advance decision is a statement made by a person with mental capacity stating their wish to refuse consent to a potential future treatment if they should later lack mental capacity. Accordingly, the statement only becomes effective if the person, at a later date, lacks the mental capacity to make a decision regarding the treatment in question. The Act asserts the legal authority of advance decisions and makes it clear that they must be followed when *valid* and *applicable* to the treatment proposed. The Code of Practice (para 9.8) states:

> '… *healthcare professionals should always start from the assumption that a person who has made an advance decision had capacity to make it, unless they are aware of reasonable grounds to doubt the person had the capacity to make the advance decision at the time they made it.'*

Law and Code of Practice

The statutory powers and rules for advance decisions are contained in sections 24-26 of the Act and chapter 9 of the Code of Practice provides further guidance.

Requirements

In order for an advance decision to be valid in law, the person must have the mental capacity to make it and be at least 18 years old. The treatment being refused should be specified even if it is described in lay terms, for example *'do not put me on a machine that breathes for me'*. The Code of Practice (para 9.11) expands on the requirement to specify the treatment, explaining it:

> *'... must state precisely what treatment is to be refused – a statement giving a general desire not to be treated is not enough …'*

Some people may however wish to refuse all medical intervention. This may be problematic in practice if an attempt was made to list every possible medical intervention and equally difficult to apply in emergency situations. In these circumstances, the Code of Practice (para 9.13) states:

> '*An advance decision refusing all treatment in any situation (for example, where a person explains that their decision is based on their religion or personal beliefs) may be valid and applicable*.'

Verbal advance decisions

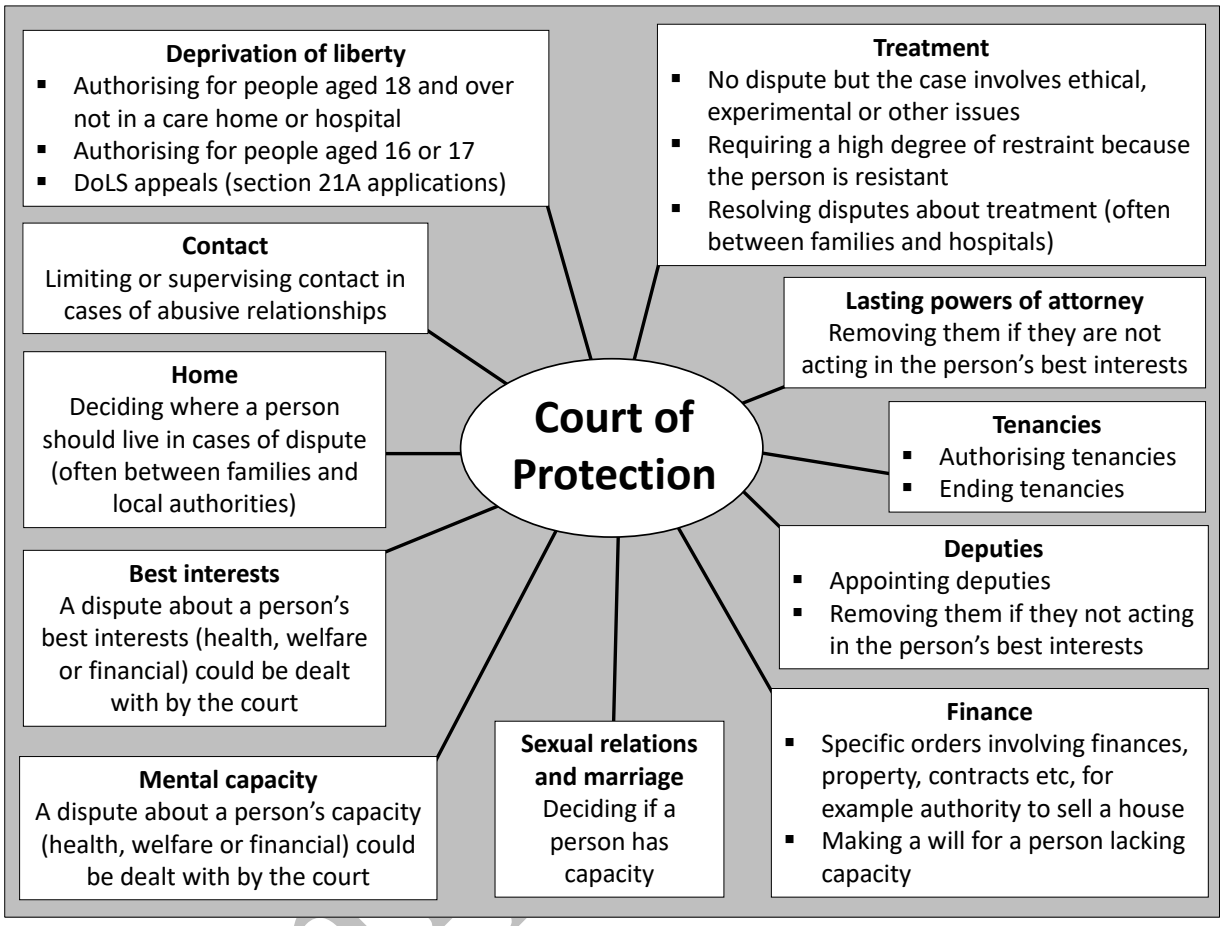
A verbal advance decision can be valid except when it is refusing life-sustaining treatment. The advantage of this is that it enables someone at the last moment to state their wishes even though they perhaps had never thought about making such a decision before. Although there is no set format, the Code of Practice (para 9.23) gives guidance to healthcare staff on how to record this type of advance decision.

- *'a note that the decision should apply if the person lacks capacity to make treatment decisions in the future*
- *a clear note of the decision, the treatment to be refused and the circumstances in which the decision will apply*
- *details of someone who was present when the oral advance decision was recorded and the role in which they were present (for example, healthcare professional or family member), and*
- *whether they heard the decision, took part in it or are just aware that it exists.'*

Lasting Powers of Attorney (LPA): What? Why? How?	
What?	The right to appoint a person(s), when you have mental capacity, who you trust to make decisions about your care, treatment and/or finances should you lose capacity to make these decisions in the future.
Why?	It allows people who have capacity to plan ahead for a time when they may lack capacity. It enables people, through a person they choose, to take control of future care, treatment and financial decisions should they lack capacity to make those decisions in the future. Example: for someone with an early diagnosis of dementia they provide a legal right to ensure future decisions about care and treatment (if they lack capacity) will be made on their behalf by someone they know and trust.
How?	Download a form or complete one online at: *www.gov.uk/power-of-attorney/make-lasting-power* Once completed it will need to be signed, witnessed and certificated. Then it should be sent to the Office of the Public Guardian to be checked and registered. There is no need to use a solicitor.
Legal criteria	The person is aged 18 or over and has capacity to make an LPA **and** one or more people who agree to become their attorney if they lack capacity in future **and** one or more people to 'certify' the form (similar to a passport application) **and** completion of an LPA form available from the Office of the Public Guardian **and** the form must be sent to the Office of the Public Guardian to be checked and then registered as valid.
Who is involved?	The person making the LPA, one or more people who agree to become attorneys and one or more people to certify the form. The Office of the Public Guardian checks and registers the forms as valid.
Limits	Health and welfare LPAs only come into force once a person lacks capacity. A financial LPA can come into force even when the person concerned still has capacity if they agree to this.
Practice points	To check whether an LPA is registered, the Office of the Public Guardian provides a free checking service. Go online and complete Form OPG100. *www.gov.uk/government/publications/search-public-guardian-registers* Attorneys are bound by the Act and have to make decisions for the person in their best interests (see chapter *Best interests Decisions)*. Concerns about an attorney should be reported to the Office of the Public Guardian.
Law and Code	Sections 9-14 and Schedule 1 of the Mental Capacity Act. Chapter 7 of the Code of Practice cover lasting powers of attorney. Schedule 4 of the Mental Capacity Act covers enduring powers of attorney.

COURT OF PROTECTION

The Court of Protection rules on all matters related to the Mental Capacity Act. It can make judgments on healthcare, social care and finances in relation to people who lack mental capacity. Its scope and influence has grown considerably since it was created, reflecting the wide scope of the Act itself. Many of its judgments are referenced in this book.



Law and Code of Practice

The statutory powers of the court are contained in sections 15-18 and 45-49 of the Act. Detailed legal guidance on the practical operation of the court is contained in the *The Court of Protection Rules 2017.* The Rules (as they are known) allow for further *Practice Directions*, to be issued which provide information on the court's procedures, for example the methods available to enforce judgments or orders. Practice directions are made by the President of the Court of Protection and approved by the Minister of State for Justice and Civil Liberties. The most recent version of the Practice Directions were released in December 2017 *(www.judiciary.gov.uk/publications/court-of-protection-practice-directions)*. In relation to the authority of Practice Directions the Court of Appeal *(Director of Legal Aid Casework & Ors v Briggs [2017] EWCA Civ 1169)* has stated:

> *'Insofar as the Code and the Practice Direction appear to be inconsistent the one with the other, it is the Code which must therefore take precedence.'*

Chapter 8 of the Code of Practice provides further guidance on the Court of Protection.

TENANCY AGREEMENTS AND THE MENTAL CAPACITY ACT

A tenancy agreement is only valid if a person has mental capacity to enter into the agreement. It is extremely important that local authority staff, housing providers and others involved in accommodating or moving people into placements understand how to assess a person's mental capacity to sign such agreements.

In this chapter, we are going to focus on the word 'agreement'. People enter into agreements all the time. Sometimes they are recognised more formally, such as getting married and sometimes less formally, such as borrowing £5 from a friend with the promise it will be returned. However, can there be a valid tenancy agreement when the proposed tenant has a condition of the mind or brain which *causes* them to be unable to understand, retain, or use or weigh up (even with support) what the agreement is about? In these circumstances, the agreement could be cancelled even if someone was compliant. For example, a housing officer may have put the agreement in front of a person and said 'please sign this', knowing it was unlikely that they had the mental capacity to understand it. In this case, their compliance would not make a difference to the right to have the agreement cancelled (case of *Imperial Loan Co. Ltd v Stone [1892] 1 QB 599).* A tenancy agreement is a formal contract and so if a person lacks mental capacity to sign it, this has important consequences.

Note: Although the Mental Capacity Act largely applies to those aged 16 or over, because of other legal limitations in terms of contract law, this chapter only applies to those aged 18 or over.

What is the problem?

Around the country, some local authorities have presented their clients or service users with tenancy agreements and asked them to sign, even though they are aware the person does not have the mental capacity to enter into the agreement. Alternatively, some professionals have asked another person to sign on behalf of the individual lacking mental capacity, even though that other person had no legal authority to do so. In some cases, managers of supported living placements have signed in place of a tenant who lacks mental capacity, again without legal authority.

Unsigned tenancy agreements

Whilst it is true that technically, a tenancy agreement does not have to be signed to be valid, an *agreement* can only exist if the parties to it (or someone else with authority) actually *enter* into the agreement. This applies even if there is an unsigned document produced with the heading 'tenancy agreement' naming the relevant parties.

Common mistakes

Below are some common mistakes made by local authorities (and others) which will be addressed in this chapter:

1. Not assessing and recording whether a person has mental capacity to sign even if there are doubts about their ability to understand the agreement.
2. Housing officers mistakenly believing this assessment has already been carried out by another professional, such as a social worker or a doctor. As mental capacity is decision specific, these other professionals may have assessed mental capacity but it could be about a different decision such as medical treatment or residence. Not necessarily about the terms of the contract (the tenancy or licence) and potential consequences such as the risk of eviction.
3. Asking a proposed tenant to sign when they know the person does not have the mental capacity to do so.
4. Asking another person to sign on their behalf, even though the other person does not have authority to sign. For example, someone who is noted in the records as *next of kin* but does

SAFEGUARDING ADULTS AND THE MENTAL CAPACITY ACT

The connection between safeguarding adults and the Mental Capacity Act is considerable. People who lack mental capacity to make certain decisions are often more vulnerable and at risk of abuse. The *care and support statutory guidance* issued by the Department of Health under the Care Act 2014 states (para 14.58):

> *'Mental capacity is frequently raised in relation to adult safeguarding. The requirement to apply the MCA in adult safeguarding enquiries challenges many professionals and requires utmost care, particularly where it appears an adult has capacity for making specific decisions that nevertheless places them at risk of being abused or neglected.'*

There is a considerable body of case law where local authorities have acted unlawfully in safeguarding adults cases because they have tried to exert powers they did not possess over private incapacitated individuals. On many occasions, this was because they mistakenly believed that the safeguarding process or the Care Act gave them such powers. Often, the appropriate course of action would have been to obtain a court order under the Mental Capacity Act. This has been most notable in cases involving the removal of an adult lacking mental capacity from family because of safeguarding concerns. In the case of *NCC v WMA & MC [2013] EWHC 2580* detailed later in this chapter, the judge stated:

> *'Certainly it is a rather strange approach apparently to concentrate on safeguarding rather than best interests ... I do not think it is my role in this case to criticise all the procedures of the local authority, rather to urge them to take a review of how they deal with best interests issues in the future and how they structure the department.'*

The key lesson for any staff involved in safeguarding is that although the Care Act 2014 put safeguarding adults on a statutory footing, it did not provide any powers to control individuals; merely a duty to investigate concerns. Where an adult lacks mental capacity, the use of the Mental Capacity Act will be of central importance in order to safeguard them.

An example of how the powers of the Act could be applied

A woman with dementia has been cared for at her daughter's home. Social workers have raised a number of concerns about the care provided by the daughter and, over time, the situation has deteriorated. The daughter refuses to allow her mother to be moved to a residential care home despite the social worker and district nurse assessing that her care needs require this. The woman lacks mental capacity to say whether she wishes to remain with her daughter or live elsewhere. The daughter has refused physical adaptations to her property that the community occupational therapy service assess as necessary to deliver a care package in the mother's best interests. Over time, the daughter becomes increasingly hostile to any more involvement by social services and refuses any further visits to assess her mother. A referral is made to the safeguarding team in the local authority.

The Act could be used to take the following action:

1. **Court of Protection** – the local authority could apply to the court so a judge can make a decision about whether the woman should be removed from her daughter's home. The court could make a decision that the woman should be placed in a care home instead, if that is in her best interests.
2. **Deputy** – the court could appoint a deputy to make future health and welfare decisions on behalf of the woman to avoid further lengthy court hearings. The court would decide on the extent and duration of the deputy's powers.
3. **IMCA (advocate)** – the mother has a potential right to independent advocacy because her case was subject to a safeguarding investigation.
4. **Contact** – if the daughter was visiting her mother at the care home and there were concern about the visits, (perhaps because she was being aggressive or abusive towards her mother) the court could issue an order prohibiting, limiting or ensuring supervised contact with the daughter. The staff could not do this without official authority from the court.

USING THE MENTAL CAPACITY ACT – DIFFERENT SERVICES

The Act covers all health and social care providers and this chapter aims to highlight the use and application of the legislation by different staff and organisations. The authors of this book have trained staff from all the services listed below and although the legislation is uniform in its content, its application to different situations varies, reflecting the nature of the services concerned.

1. Police
2. Ambulance staff and paramedics
3. General practitioners (GPs)
4. Hospices
5. Mental health services (inpatient and community)
6. Acute hospitals
7. Clinical commissioning groups (CCG)
8. Care homes (residential and nursing)
9. Dentists
10. Local authorities (social services)
11. Prison healthcare

1. Police

In 2012, the Metropolitan Police were taken to court by the family of a 19 year old man with severe autism (*ZH v Commissioner of Police for the Metropolis [2012] EWHC 604 (QB)*). The case related to a number of different legal issues but a central component was the claim that the police officers involved had failed to use the Mental Capacity Act when they made the decision to physically restrain the young man in a public swimming pool. The police claimed the Mental Capacity Act did not apply as their officers had acted honestly and in good faith and their actions were lawful under the common law defence of necessity. The High Court disagreed and said they should have used the Mental Capacity Act. The judge stated:

> *'It is not sufficient for the Defence to establish simply that an officer acted honestly and in good faith ... For my part I am satisfied that where the provisions of the Mental Capacity Act apply, the common law defence of necessity has no application.'*

The failure to use the Act meant the actions of the officers involved were unlawful and the judge awarded substantial damages to the young man. The police subsequently appealed the judgment and three senior judges in the Court of Appeal considered the case again (*ZH v the Commissioner of Police for the Metropolis [2013] EWCA Civ 69)*. The judges reached a unanimous decision that the first judgment was correct and so the police lost the appeal. Lord Dyson, one of the judges involved, stated:

> *'I start with a few general observations about the MCA with particular reference to the acts done by police officers directed at the care of a person who lacks capacity. Where such acts would otherwise attract liability for the torts of assault and false imprisonment, they will not do so if (i) the officers reasonably believed that the person lacked capacity (having taken reasonable steps to establish whether that was so (section 5(1)(a) and (b)(i)); (ii) they reasonably believed that those acts were done in the person's best interests (section 5(1)(b)(ii)); and (iii) in the case of a restraint, they reasonably believed that they were necessary in order to prevent harm to the person and that it was a proportionate response (section 6(2) and (3)).'*
>
> *'As I have said, the Mental Capacity Act does not impose impossible demands on those who do acts in connection with the care or treatment of others. It requires no more than what is reasonable, practicable and appropriate.'*

The significance of this case is many fold and includes:

1. If the police, who are not normally viewed as formal health or social care providers, can be taken to court for failing to use the Act then certainly all 'official' health and social care providers (GPs, hospitals, ambulance staff, social workers, care home staff etc) can also be challenged.