HALTON BOROUGH COUNCIL

People Directorate - Adult Social Care

DRAFT
Mental Capacity Act 2005

Policy, Procedure and Practice
August 2016

CONTENTS

INFORMATION SHEET

Service area	People and Economy Directorate – Adult Social Care
Date effective from	
Responsible officer(s)	Divisional Manager (Mental Health)/ Divisional Manager (Independent Living)
Date of review(s)	August 2016
Status: • **Mandatory (all named staff must adhere to guidance)** • **Optional (procedures and practice can vary between teams)**	Mandatory/Statutory
Target audience	Adult Social Care staff within the People and Economy Directorate
Date of committee/SMT decision	
Related document(s)	• Deprivation of Liberty Safeguarding (DoLS) Policy, Practice and Procedure – March 2016 • Mental Capacity: Advance Planning – August 2016 • Restrictive Physical Interventions - Policy, Procedure and Practice - For Professionals Working With: Adults of all ages within a supported housing aspect of direct care services - January 2015 • Mental Health Act 1983 • The Deprivation of Liberty Safeguards 2008 • Care Standards Act 2000 • Care Act 2014 • Data Protection Act 1998 • Human Rights Act 1998 • Safeguarding Vulnerable Groups Act 2006 • The Protection of Freedoms Act 2012
Superseded document(s)	Mental Capacity Act 2005 Policy, Practice and Procedure – December 2013
Equality Impact Assessment completed	

1.0	POLICY	*PRACTICE*
1.1	**Introduction** The Mental Capacity Act (MCA) 2005 sets out statute applicable to England and Wales. It came into force in 2007 and represents an important part of health and social care practice. The legislation determines a framework for acting, and making decisions, on behalf of people (over 16 years of age) who lack the mental capacity to make specific decisions for themselves. The MCA and associated Code of Practice establish how capacity is determined. It aims to ensure that any decision made or action taken on behalf of an individual, who lacks the capacity to make that decision themselves, will always be made in their **best interests**. The MCA sets out five statutory principles which are designed to empower and protect individuals. It makes it clear who can make decisions, in which situations and how they should go about this. It also enables people to plan ahead for a time when they may lose capacity.	*The MCA provides a statutory framework within which staff must work with service users when determining capacity and best interest decisions. Careful adherence to the Act and its Code of Practice (CoP) will protect those working with individuals who lack capacity provided that decision-making processes are fully recorded and any decisions justified.* *Decisions around capacity concern the basic rights and principles set out in the Human Rights Act 1998.*
1.1.2	**The Principles of the MCA:** • A person must be assumed to have capacity unless it is established that they lack capacity. • A person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success. • A person is not to be treated as unable to make a decision merely because they make unwise decisions. • An act done or decision made, under the Act for or on behalf of a person who lacks	*There are certain decisions that can never be made on behalf of a person lacking capacity, either because such decisions are too personal to the individual concerned or because they are governed by other legislation. These decisions concern: family relationships, treatment under the Mental Health Act, voting rights, unlawful killing and assisted suicide.*

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	capacity must be done, or made, in their best interest. • 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.	
1.2	**Policy Remit** The overall aim of this Policy is to ensure that: • Staff working within the requirements of the MCA have a clear understanding of their roles and responsibilities. • Practice is consistent and in-line with case-law developments. • Operational processes and paperwork are unified and coherent. • Individuals with capacity issues receive the support which is appropriate and proportionate to their needs. • Information about the MCA is accessible to families, carers and the public. • Independent Mental Capacity Advocates (IMCA) services are appropriately allocated. • The training and development needs of the workforce are identified and delivered. • Systems are in place to support relevant multi-agency collaborations and associated partnerships.	*This policy is to be read in conjunction with the MCA, the Code of Practice and related documents as described in the information sheet. It does not supersede any of the associated statute but is intended as a guidance document to drive the local response to mental capacity issues.* *Halton's partner agencies may wish to work within the values of this policy. They may also have developed their own MCA procedures and guidance, specific to the needs of their own context and function, while remaining within the scope of the MCA and related legislation and guidance. Consequently, where partnership working or multi-agency collaboration is taking place this policy must be read in conjunction with any specific agency policies and procedures.*

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1.3	**Safeguarding Adults in Halton** Safeguarding the welfare and wellbeing of individuals is integral to Halton Borough Council's (HBC) responsibilities and one of its strategic priorities, aligned to the provision of 'A Safer Halton'. Safeguarding is everyone's business. Staff within HBCs Adult Social Care teams and across the Health and Social Care sector in Halton will frequently play a key role supporting and helping people with impaired mental capacity and functioning. In the course of doing this they must ensure that they protect those people. This includes protecting them from harm, coercion and control, abuse, neglect or exploitation. It involves promotion of their wellbeing, their views, wishes and feelings, their beliefs, dignity and right to independence. The values are fundamental to the provision of high-quality health and social care services. **Staff should always work on the basis of an assumption of capacity**. Specific decisions or actions may need to be taken where an adult has shown to lack capacity. HBC is committed, on behalf of all partner agencies, to the principles and objectives of the Mental Capacity Act. Staff may help a service-user to understand what decisions have to be made, why they are important and what the consequences of making them are likely to be. Occasionally, those in health and social care roles are the only people in a position to provide information to such individuals about the options available to them and where they can obtain help, further information and advice. Staff should not make decisions on people's behalf, unless a lack of capacity has been determined, and the decision being made has been determined as	*Local Authorities, under the Care Act 2014, have a set of legal duties and responsibilities. These include the requirement to lead multi-agency systems including establishing a Safeguarding Adults Board to develop, share and implement a joint safeguarding strategy. They have the responsibility to make or request safeguarding enquiries; carry out safeguarding adults' reviews; and appoint independent advocates to support those subject to an enquiry or review, as required.* *Section 42 of the Care Act defines risk of abuse to include 'financial abuse'. The Bournemouth University Financial Scamming guide calls for all agencies to recognise that "consumers / clients with dementia [and therefore others with capacity issues] are by definitions more at risk of being scammed... measures to protect this population group are required as part of a 'duty of care'."*

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	being in their best interest.	
1.3.1	Halton Borough Council will: • Safeguard and meet the needs of adults who may lack capacity by working with service users, carers and partner agencies to implement the principles and aims of the Mental Capacity Act 2005. • Ensure that all staff are aware of and able to work with partner agencies as a means of meeting the needs of people lacking capacity. • Work in partnership wherever possible with people who lack capacity as well as their carers in order to provide treatment and services that are in their best interests. • Safeguard the interests of people who lack capacity where they are without support or considered to be at risk of abuse.	
1.4	**Who does this Policy apply to?** The Policy applies to all those covered under the MCA, and all those working with the legislation and its related Code of Practice. The MCA applies to all people over the age of 16 years old* who may lack capacity to make specific decisions.	**Exceptions:* *1. Only those 18 and above can make a 'Lasting Power of Attorney'.* *2. Only those 18 and above can make an 'Advance Decision' to refuse medical treatment.* *3. The Court of protection can only make a 'statutory*

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	This includes people with: • A severe learning disability. • A mental health problem, including those whose condition can be variable. • Dementia. • Cognitive impairments as a result of a stroke or an acquired brain injury. It is important to keep in mind that these conditions or illnesses do not in themselves mean that a person lacks the capacity to make a particular decision. The MCA is intended to be a provision that is enabling and supportive of people who lack capacity, not restricting or controlling of their lives. Although it clearly protects such people, it also aims to promote maximum involvement by people in decisions that affect them. Application of the MCA and the associated Code of Practice allows people to take appropriate action in individual cases and helps people to find solutions to difficult or uncertain situations. The MCA also applies to all those people who come into contact with people who may lack capacity. This includes (but is not limited to) family, friends and neighbours, professional health and social care and support staff, residential and nursing homes, lawyers and courts. It is important that registered professionals and other workers promote awareness of the MCA and are aware of their own responsibilities under it – See Sections 2.1 and 2.3.	*will' for a person aged 18 and over.* *This is not an exhaustive list and there may be other circumstances where capacity is determined. This will involve the same assessment process.* *Code of Practice, Chapter 2, page 20.* *Section 2.3 details how capacity is assessed by using a two-stage test.* *Appendix Four provide the structure, documentation and information required by staff working in the best interests of people lacking capacity.*
1.5	**The MCA Code of Practice** The MCA Code of Practice (CoP) is a comprehensive guidance documents intended for	

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	use in conjunction with the legislation. The CoP provides additional information about how to put the MCA into practice. The MCA does not impose a legal duty on anyone to 'comply with the Code,' so it should be viewed by staff as best practice guidance. However, if a person **does not** follow the relevant guidance they must give a good reason why they have deviated from it. The MCA and the CoP should be seen together as a statement of best practice to be followed by staff in all matters. Hence any staff member working with an individual who has been assessed as 'lacking capacity' must act within the provisions of the Act and the CoP.	
1.6	**Interface with the Mental Health Act** There may be situations where the Mental Health Act 1983 (As amended by the 2007 Act) is the most appropriate legislation to apply to a person's care and treatment. It ensures that those with serious mental disorders receive care and treatment, even against their wishes. Here, decision-making capacity may be held but decisions made may not just be unwise but may be detrimental to the health and safety of the person or those around them, or pose a risk of this.	
1.6.1	The Mental Health Act (MHA) sets out circumstances when those with mental disorders can be: **a.** Detained in hospital for assessment or treatment; **b.** Detained and given treatment for their mental disorder without their consent; or **c.** Made subject to Guardianship or after-care under supervision to protect themselves or others.	*Where the MHA allows individuals to be treated for mental disorders, the MCA applies in the normal way to treatment for physical disorders. Healthcare staff may decide to focus initially on treating the mental disorder in the hope that capacity will be regained, so that a decision can be made about the physical disorder.*

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	In general the MHA does not distinguish between those who have the capacity to make decisions and those who do not. Most people who lack capacity to make decisions about their treatment will never be affected by the MHA, even if they require treatment for a mental disorder. However there are situations where decision-makers must decide whether to use the MHA, MCA or both in order to meet the needs of individuals with mental ill health who lack capacity to make decisions about their own treatment. A key question for the decision-maker looking at the MHA is therefore whether no alternative solution is available under the MCA and the criteria under the MHA are genuinely met.	*The MHA and the MCA and their associated Codes of Practice as well as current case law should be taken into account in these situations.*
1.6.2	Before deciding whether to admit (to a hospital setting), treat and detain a compliant, incapacitated patient under the provisions of the MHA, consideration should be given as to: • Whether or not admission and treatment can be achieved under the application of the MCA/DOLS* regime instead, and whether that regime would be less restrictive than detention under the MHA. *It might be necessary to consider using the MHA rather than the MCA if: 1. The person cannot be provided with the care or treatment they need without being deprived of their liberty (and they do not meet the criteria for DoLS under the MCA). 2. The required treatment is not available under the MCA because the person has made an Advance Decision to refuse all or part of that treatment. Here, the MHA may annul the Advance Decision. 3. The person must be restrained in a way that is not allowed under the MCA. 4. It is not possible to assess/treat the person safely or effectively without the treatment being compulsory (i.e. the person could regain the capacity to consent, but on doing so might refuse to give consent). 5. The person lacks capacity to decide some elements of treatment, but has the capacity to refuse vital parts of it and have done so. 6. There is some other reason why the person might not get the treatment they need and they	*Practitioners do not have to apply to the Court of Protection to rule the MCA does not apply before using the MHA, The MHA always has precedence over the MCA. Similarly, if a practitioner believes that they can safely assess or treat a person under the MCA, they do not need to consider using the MHA.* *A person detained under the Mental Health Act (and Mental Health Code of Practice) needs to meet the specified criteria for detention. This sets out that they will be suffering a mental disorder of a nature or degree which warrants detention and/or treatment, and that the detention is in the interest of their own health and safety or with a view to the protection of others.*

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	or others may suffer harm as a result. Section 5 of the MCA provides legal protection for those who care or treat someone lacking capacity, but in doing so they must follow the Act's principles and may only take action that is in the person's best interests. However, there is no protection under Section 5 for any actions that deprive a person of their liberty. Similarly, the MCA disallows giving treatment that is contrary to a valid and applicable Advance Decision to refuse treatment. None of these restrictions apply to treatment for mental disorder, though others do.	*This will also include the need to have an awareness of the Deprivation of Liberty Safeguards as outlined in Section 1.7.11.*
1.6.3	It is important for health and social staff who support certain client groups (for example, those with mental health problems, particularly those with severe and enduring mental ill health or older people) to have an understanding of the interface issues between the MCA and the MHA.	
1.7	**Definitions**	
1.7.1	**"*Advance Decisions*"** may be made by someone with capacity (over 18 years of age) who wishes to refuse specific treatment(s). An 'advance decision' will then apply at a future time should the person lose capacity. The treatment(s) which a person wishes to refuse must all be specified in the 'advance decision', including the circumstances in which the decision applies. Where a person wishes to make an advance decision to refuse life-sustaining treatment (sometimes known as a 'living will') the decision must be written down, signed by the person making the decision and witnessed (this will normally be a professional who would be in a position to confirm that capacity is held e.g. GP). An advance decision is legally binding, as long as it meets the necessary criteria (including being within the confines of what it can legally be used for) for it to be considered valid and applicable.	*See: Chapter 9, MCA Code of Practice.* *Also:* Halton Borough Council's Mental Capacity: Advance Planning – Policy Procedure and Practice, August 2016.
1.7.2	**"*Advance Statements*"** sets out a person's views,	

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	wishes and preferences regarding their care and treatment in the future. They can cover details of how a person would like to be cared for, for example, at home, in a hospital, care home or hospice. They may cover what the person likes to do, for example, take a bath instead of a shower. They may also cover spiritual or religious beliefs the person would like reflected in their care. Unlike Advance Decisions these are not legally binding but serve as a set of clear instructions for family, friends or anyone involved in arranging care and treatment. By making an advance statement a person who may lose capacity at a future point is able to communicate their wishes and state their individual values.	
1.7.3	**"*Best Interests*"** is a core principle that underpins the MCA. It stresses that any act done or decision made on behalf of an individual who lacks capacity, must be done or made in their best interests. This principle covers all aspects of financial, personal welfare, health care decision-making and actions. The decision-maker must involve the person in the decision as fully as possible, making every attempt to communicate outcomes. Where capacity fluctuates they must consider whether the person may be able to make the decision for themselves at another time. Best interest involves not making decisions based on assumptions about the person, consideration of the circumstances of the decisions that need to be made and respect of any previously stated wishes, values or preferences.	*See: Chapter 5, MCA Code of Practice.*
1.7.4	***"Care Quality Commission (CQC)"*** is a non-departmental public body of the UK government established in 2009 to regulate and inspect health and social care services in England. This includes services provided by the NHS, local authorities, private companies and voluntary organisations – whether in hospitals, care homes or people's own homes. Part of the CQCs remit is to monitor use of the MCA and DoLS.	
1.7.5	**"*Carers*"** provide informal care and support to a person (partner, relative, friend or neighbour) who through illness or disability is unable to look after her/himself. The carer may be an adult, young	*Under the Care Act 2014 carers have a legal right to assessment of their own needs and may be entitled to*

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	person or child. The role of a carer is not the same as someone who provides care professionally or through a voluntary organisation.	*support based on the impact of their caring role on their own life.*
1.7.6	**"*Children*"** – The MCA Code of Practice has provisions for dealing with cases where a person is deemed a child (under 16). This involves specific circumstances under which the Court of Protection can made decisions about those who are under 16 years of age and who lack capacity.	*See: Chapter 12, CA Code of Practice*
1.7.7	**"*Consent*"** is the voluntary and continuing permission of the person to the intervention or decision in question. It is based on an adequate knowledge and understanding of the purpose, nature, likely effects and risks of that intervention or decision, including the likelihood of success of that intervention and any alternatives to it. Permission given under any unfair or undue pressure is not consent.	
1.7.8	**"*Court Appointed Deputy (CAD)*"** - A CAD is appointed by the Court of Protection with legal authority to make decisions on behalf of an individual lacking capacity to do so themselves. They are often family members or friends, but can also be professionals such as solicitors or local authorities. The decision-making powers of a CAD may be defined in scope and duration by the Court of Protection.	
1.7.9	**"*Court of Protection*"** is a specialist court dealing with all issues relating to people who lack capacity to make specific decisions. It is responsible for dealing with contested decisions; determining the outcomes of disputes around enduring or lasting powers of attorney; appointing and monitoring CADs and/or trustees and making statutory wills. See Section 2.6.	
1.7.10	**"*Decision-Maker*"** - The individual who is responsible for deciding what is in the *best interests* of a person who lacks capacity and who makes a decision on their behalf. The decision maker can be a professional, family	

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	member, carer or other. The decision-maker for different aspects of a person's life (their care, treatment or financial choices) may be the person who is appropriately skilled and knowledgeable and who best legally placed to make the decision. Any disputes on these matters can be settled by the Court of Protection. Decisions made on behalf of someone who lacks capacity can be made jointly between care professionals and family/friends, provided they are made in their *best interest*.	In the application of a DoLS this may be the 'Relevant Person's Representative' (RPR).
1.7.11	**"*Deprivation of Liberty Safeguards (DoLS)*"** provide a legal framework and right of appeal to ensure that adults lacking mental capacity are properly represented and not deprived of their liberty unless it is in their best interest. DoLS have been established to protect the rights of individuals who, for their own safety, need to be detained or subject to supervision and control in respect of their care and treatment. DoLS ensure that any decision taken to deprive someone of their liberty is made according to well-defined processes, thoroughly documented and carried out in consultation with specific authorities. They do not cover detention under the Mental Health Act.	*For definitions of roles and responsibilities under DoLs see: Halton Borough Council's Mental Capacity Act – Deprivation of Liberty Safeguards (DoLS) - Policy, Procedure and Practice - March 2016*
1.7.12	**"*Donor*"** – this is the individual who makes a Lasting Power of Authority (LPA) to appoint another person to manage their assets or to make personal welfare decisions (prior to October 2007 an Enduring Power of Attorney). The LPA will make decisions on behalf of the donor should they lose capacity at a future time.	
1.7.13	**"*Enduring Power of Attorney (EPA)*"** - This is a power of attorney created under the Enduring Powers of Attorney Act 1985 to deal with property and financial affairs. Existing EPAs made before this time continue to be valid.	
1.7.14	**"*Independent Mental Capacity Advocates (IMCA)*"** can be appointed (by a Local Authority or NHS body) to represent and support an individual who lacks capacity in situations where the person	

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	has no one else to support them. IMCAs can also be taken on to support carers to understand and evaluate decisions that need to be made in someone's best interest. The IMCA role is a paid position. They provide independent and impartial information and guidance and represent the views and wishes of the person who lacks capacity.	
1.7.15	**"*Lasting Power of Attorney (LPA)*"** is a way of giving a trusted person decision-making responsibility where mental capacity may be lost at a later time. A *donor* can appoint an attorney or attorneys act on their behalf in matters relating to welfare, including healthcare, and/or financial dealings, such as their property or monitory affairs. An LPA must be registered with the Office of the Public Guardian (OPG) before it can be used. A donor can only make an LPA while they still have capacity.	*A donor must be over 18 years of age and have capacity at the time of appointing the Attorney.* *The making and registration process for a Lasting Power of Attorney can take around six weeks, during which time people can object to the registration of the LPA.* *An LPA for property and finance can be activated immediately; an LPA for welfare only triggers after the person loses capacity.*
1.7.16	**"*Managing Authority*"** - The person or body with management responsibility for the hospital, care home or sheltered housing accommodation in which a person is or may become deprived of their liberty.	
1.7.17	**"*Mediation*"** - This is a voluntary process undertaken to enable two or more parties to reach a mutually acceptable outcome. Parties who take part in mediation may be empowered by an independent mediator or facilitator to resolve the dispute themselves. Unresolved disputes regarding a person, who lacks capacity to make decisions for themselves, or in relation to whether capacity is held, can be taken to the Court of Protection.	*Disputes about the finances of a person who lacks capacity should usually be referred to the Office of the Public Guardian (OPG).*
1.7.18	**"*Mental capacity*"** broadly refers to the ability of an individual to make decisions and choices about specific elements of their life. This can include anything from meal choices through to decisions on health treatment. Different decisions require different levels of understanding and assessment of	

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	whether capacity is held has to take this into account. The MCA and its CoP refer specifically to a person's capacity to make particular decisions at the time an assessment needs to be made. Any restrictions placed on a person lacking capacity must be lawfully made, proportionate and in the person's best interest. This may include decisions being made on their behalf, action being taken on their behalf or a deprivation of liberty.	
1.7.19	**"*Office of the Public Guardianship (OPG)*"** - The OPG: supervises CADs; keeps a register of deputies, LPA and EPAs; monitors attorneys; and investigates any complaints about attorneys or deputies.	
1.7.20	**"*Restraint*"** is using force or threatening to do so in order to stop someone doing something they are resisting. It is also defined as restricting a person's freedom of movement, whether they are resisting or not. The appropriate use of restraint always falls short of depriving a person of their liberty.	*See also: Restrictive Physical Interventions - Policy, Procedure and Practice - For Professionals Working With: Adults of all ages within a supported housing aspect of direct care services - January 2015.*
1.7.21	**"*Statutory Will*"** – If someone lacks the capacity to make a will it is possible for an interested party to apply to the Court of Protection to make a statutory will for that person. Someone with LPA, or a CAD, does not have the authority to make decisions on setting or changing a will. Statutory wills will normally be made on behalf of someone lacking capacity where no will exists. However, in some cases, where strong evidence exists to show that a will no longer represents the views and wishes of the person who lacks capacity, changes may be made by the Court of Protection.	*A will is a legal document that sets forth a person's wishes regarding the distribution of their property, possessions and financial assets. It may involve provisions for the care of children.*
1.7.22	***"Supervisory Body"*** – The Local Authority within which a person has 'ordinary residence' is responsible for conducting assessment for a standard DoLS authorisation.	*'Ordinary Residence' is normally determined by the geographical area the person lived immediately prior to entering the accommodation to which the*

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		DoLS applies.
1.7.23	***"Wilful neglect"*** - The MCA covers definition of the criminal offences of ill-treatment and wilful neglect of a person who lacks capacity.	*A referral to the Police should be made for those in danger of immediate harm. Care Concerns are to be raised with Quality Assurance team and Safeguarding issues should be reported initially through the Contact Centre.*
1.7.24	**"*Young People*"** – The MCA defines this group of people as those aged between 16 and 17 years old. The MCA applies to those over 16 years of age with three exceptions: Only people aged 18 and over can make a Lasting Power of Attorney (LPA); Only people aged 18 and over can make an advance decision to refuse medical treatment; and the Court of Protection may only make a Statutory Will for a person aged18 and over.	*Deprivation of Liberty Safeguards (DoLS) have normally applied to those over 18 years of age. However in Birmingham v D (2016) a young person, aged 16, was voluntarily accommodated, with the consent of his parents, in circumstances that amounted to a Deprivation of Liberty, due to his lack of capacity to consent in person.* *This recent case could have implications for DoLS and their application to young people. Readers should be mindful of developments stemming from this judgement.*

2.0	**PROCEDURE**	***PRACTICE***
2.1	**Mental Capacity** Mental capacity is the ability to make a decision, ranging from something minor that affects daily life only, to a more significant decision with much wider implications. Everyone has the right to make decisions for themselves, provided they have the capacity to do so. The MCA sets out processes and principles for working with those who may lack capacity. Proactive application of the MCA ensures that people's care and treatment is appropriate, proportionate and not overly restrictive or controlling. Where a lack of capacity has been established the MCA provides a legal framework within which decisions can be made and actions can be taken on a person's behalf.	*Those who access the services and support offered through Halton Borough Council's Adult Social Care Services and associated commissioned functions may have impairments or disturbances of the mind or brain which will impact on their ability to make decisions.* *Capacity cannot be established merely by reference to:* • *Age;* • *Appearance;* • *Behaviour; or,* • *Diagnosis/condition.*
2.1.1	**The Principles of the MCA** The five principles of the Mental Capacity Act represent a benchmark for all those who interact with a person who may lack, or who does lack capacity to make their own decisions. Interaction made by employees of Halton Borough Council, partner agencies or commissioned services are made on a professional level and represent part of a supportive, empowering and protective relationship. The principles of the MCA deal with the challenge of protecting a person's choice and independence against the requirement to safeguard and their welfare and wellbeing. A person may make a decision that others consider unwise or wrong and may learn from their mistakes. Principles 1 – 3 account for this. People with disabilities or conditions that may impair their cognition must be allowed to do that same, if they have capacity to understand the risks associated with their decisions. On the other hand there is a clear need to protect against harm those most vulnerable in society. The Principles represent a clear	*This includes IMCA services.*

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	framework which delineates the divisions between these conflicting needs. Friends and family of a person who may or who does lack capacity are not bound by the principles, though would be well served to understand and apply them.	
2.1.2	**Principle 1:** "A person must be assumed to have capacity unless it is established that s/he lacks capacity" **(Mental Capacity Act, Section 1 (2))**.	*There must be clear documented proof (See Section 2.3 - Two-Stage Test) that a person lacks capacity about the particular decision they are being required to make.*
2.1.3	**Principle 2:** "A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success" **(Mental Capacity Act, Section 1 (3))**. This is a proactive duty on those who work with a person who may be thought to lack capacity to make a particular decision. The kind of support a person needs will depend on their circumstances. It may include: • Using a different form of communication (such as non-verbal communication). • Providing information in a more accessible form (such as photographs, drawing or other visual aids). • Treating a medical condition which may affect a person's capacity. • Having a structured programme to improve a person's capacity to make particular decisions. This principle aims to stop people being automatically labelled as lacking capacity to make particular decisions. If they play as big a role as possible in decision-making, this will help prevent	*People may require help to make or communicate a decision. This does not mean that they lack the capacity to make the decision.* *All possible steps must be taken to assist the person to make the decision. Where complex decisions are being taken, relating to a person's accommodation or treatment (including the giving of medication), these should be clearly described in the person's case notes, with a record of their success or failure and the reasons for this.* *Case notes must be signed and dated by the staff member concerned and should be specifically countersigned by the manager of the team/ service.*

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	unnecessary interventions in their lives.	
2.1.4	**Principle 3:** "A person is not to be treated as unable to make a decision merely because he makes an unwise decision" **(Mental Capacity Act, Section 1 (4)).** This can be one of the most difficult areas for families, carers and professionals alike. The Code of Practice (*page 24*) is clear, however: *"Everybody has their own values, beliefs, preferences and attitudes. A person should not be assumed to lack the capacity to make a decision just because other people think their decision is unwise. This applies even if family members, friends, healthcare or social care staff are unhappy with a decision".* An unwise decision in itself may not indicate a lack of capacity. It may be a trigger for a fuller examination of the person's capacity to make a specific decision, or indeed of the information that person may need in order to come to a fully informed decision.	
2.1.5	**Principle 4:** "An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in their best interests" **(Mental Capacity Act, Section 1 (5))**. To ensure best interests are addressed throughout, the Code of Practice (*pages 65-66*) identifies a series of steps that should be taken by someone who is making a decision or taking an action. These should: • Encourage the person to be involved in making the decision. • Find out the person's views, past and present wishes, feelings, beliefs or values. • Avoid discrimination on the basis of age, appearance, gender, sexuality, religion or any other distinguishable	*This concept of 'Best Interests' applies whoever is making the decision and whether it is a minor or major one. It covers all aspects of financial, personal welfare and healthcare.*

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	trait, characteristic or belief. • Assess whether the person might regain capacity – and if so, consider whether the decision can be delayed. • Consult others, where practical and appropriate. • Avoid restricting the person's rights.	*This means that both principles of 'best interests' and 'least restrictive option' need to be applied each time a decision or action is made on behalf of a person lacking capacity.*
	• Where the decision concerns life-sustaining treatment, do not be motivated in any way by a desire to bring about the person's death, through assumptions about their quality of life.	*Find out if the person has previously made an Advance Decision that is specific to some aspect of their treatment.*
2.1.6	**Principle 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 effectively achieved in a way that is less restrictive of the person's rights and freedom of action" **(Mental Capacity Act, Section 1 (6)).** This consideration – finding the least restrictive alternative, while continuing to consider the person's best interests – includes considering whether there is a need to act or make a decision at all.	
2.1.7	**Dignity and Candour** Dignity involves an innate right to be valued and respected. The principles and values of dignity within care are enshrined into law. All adults must be afforded the right to dignity and respect when using health and	*Following investigations into allegations of abuse against residents with learning difficulties and mental health conditions the Government commissioned: 'Transforming Care – A national response to*

2.0	**PROCEDURE**	***PRACTICE***
	social care services. The MCA and the Human Rights Act 2000 provide opportunities for people using services and their carers and advocates to challenge a paternalistic culture where professionals decide what is best for the people in their care. The ethics and values that underpin good practice in social care, such as autonomy, privacy and dignity are at the core of human rights legislation. There are ongoing tensions between adherence to these values and the need to protect people from abuse, neglect and harm. Abiding by the **Five Principles** of the MCA is fundamental to application of the law in practice. It may be reasonable to infringe a person's human rights if the action concerned is necessary, legitimate and proportionate. From 1 April 2015 all Care Quality Commission (CQC) registered providers became required to meet 'Regulation 20: Duty of Candour'. The Regulation focusses on the terms Openness, Transparency and Candour as vital measures for ensuring care and treatment is delivered safely and compassionately. It requires disclosure, as early as reasonably practicable, of any harm occurring within the course of care or treatment. For registered services the Duty of Candour is measured against existing 'Key Lines of Enquiry' within the CQC inspection process. Those services not regulated by CQC are expected to follow best practice in adopting the same values. Promoting a duty of candour is important in relation to mental capacity. It safeguards the welfare and wellbeing of those who may lack capacity to make choice about their care and treatment. It also supports protection against decisions being made for someone where capacity is held.	*Winterbourne View Hospital: Department of Health Review Final Report' (2012). The resulting proposal for a 'Model of Care' specifies dignity as a service principle and an outcome right for service users.* *The Francis Report also led to the instigation of Regulation 20: Duty of Candour:* *"The aim of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in relation to care and treatment.* *"It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology.* *"Providers must promote a culture that encourages candour, openness and honesty at all levels. This should be an integral part of a culture of safety that supports organisational and personal learning. There should also be a commitment to being open and transparent at board level, or its equivalent such as a governing body."* *(Care Quality Commission - Regulation 20: Duty of candour - Information for all providers:*

2.0	**PROCEDURE**	***PRACTICE***
		NHS bodies, adult social care, primary medical and dental care, and independent healthcare - March 2015)
2.2	**Referral process for those who may lack capacity** Anyone entering into, or currently in receipt of, Adult Social Care services through Halton Borough Council may have capacity issues. It is important that all Adult Social Care staff to have an understanding of the Mental Capacity Act and are able to recognise signs and symptoms of a loss of capacity. Also that they can identify care or treatment which may be unnecessarily restrictive or controlling, which may amount to an unlawful deprivation of liberty. Before a formal capacity assessment takes place all reasonable and practicable effort should be made to ensure that the person can make the decision for themselves. The MCA CoP says that a mental capacity assessment should be undertaken by the person who knows the person best and who feels confident in completing the assessment. In practice this will be a person who, in their course of employment in an adult social care capacity, has an established helping relationship with the person who may lack capacity. It is recognised that not all adult social care staff will feel confident and competent to undertake a capacity assessment. Within Halton Borough Council, where staff feel that a capacity assessment is warranted, they can make a referral to the Social Work teams under Care Management who will facilitate the process of assessment.	*See Section 2.8 regarding learning and development opportunities.* *This may involve presenting and communicating information in different ways; supporting the person to understand the decision; and putting them at ease, including making consideration of timing and location. There may also be a requirement to defer the decision to such a time as the person feels better able to make it.* *They should always have a level of understanding of capacity to the extent that they recognise capacity issues.* *Those staff members who know the person best and work with them on a regular basis will be involved in the assessment.*

2.0	**PROCEDURE**	***PRACTICE***
		Referral should initially be made to the Practice or Principal Managers within: • *Initial Assessment Team* • *Complex Care Runcorn* • *Complex Care Widnes* • *Adults with Learning Disabilities*
2.3 **2.3.1**	**Assessing Capacity and establishing Best Interest** **Assessment – The Two-Stage Test** Prior to the MCA assessment of capacity would have involved a referral to a psychiatrist. Now capacity assessment falls within the scope of all adult health and social care. This enables earlier decision-making and more effective use of resources. Capacity assessment can be facilitated by the Social Work teams within Care Management. This is particularly relevant where: • The decision that needs to be made is complex or has serious consequences. • An assessor concludes that a person lacks capacity, but the person wishes to challenge that decision. • Family, carers and/or professionals disagree about a person's capacity. • There is a conflict of interest between the assessor and the person being assessed. • The person being assessed is expressing different views to different people. • Somebody might challenge the person's capacity to make the decision, either at the time or later. • A person may have been abused but lacks the capacity to make decisions that will protect themselves. • A person repeatedly makes decisions that could put them at risk or could result in suffering or damage.	*Appendix One shows a Mental Capacity Assessment Flow Chart.* *Assessment of capacity should be made* ***at the time of the decision to be made.*** *All assessments and decisions are to be recorded on the CareFirst6 data management system.* *Where the person is receiving services from a multi-disciplinary team it will be the person who works most closely with the subject of the assessment who conducts the assessment, provided they are skilled and confident to undertake the assessment.*

2.0	**PROCEDURE**	***PRACTICE***
	Assessment of capacity involves a two-part test (examined in greater detail below). While taking account of the Principles of the Act (Section 2.1.1-2.1.6), this essentially asks two questions: 1. 'Does the person have impairment or disturbance in the functioning of the mind or brain?' 2. Where the answer to question one is 'yes', 'can the person make the relevant decision or not?' Part two of the assessment involves the assessor applying four further 'tests' to establish whether the person can: a) Understand the information relevant to the decision; b) Retain that information; c) Use or weigh that information as part of the process of making the decision; or d) Communicate his decision (whether by talking, using sign language or any other means).	*This first part of the assessment is often called the 'diagnostic' test for capacity. The second part is the 'functional' test.* *Where the answer to question one is 'no' then the person holds capacity.*
2.3.2	**Part 1: Establishing whether a person has either a temporary or permanent impairment of, or disturbance in the functioning of, their mind or brain.** Without this proof a person will not lack capacity under the terms of the MCA. The CoP (Page 44) gives examples of impairments or disturbances in the functioning of the brain or mind: • Conditions associated with some mental illnesses • Dementia • Significant learning disabilities • The long-term effects of brain damage • Physical or mental conditions leading to confusion, drowsiness or loss of consciousness • Delirium • Concussion	

2.0	PROCEDURE	*PRACTICE*
	• The symptoms of alcohol or drug use It should be stressed, though, that the issue is not the person's diagnosis, but their capacity to make a decision about a specific issue.	
2.3.3	**Part 2: Establishing whether the impairment or disturbance means that the person cannot make a specific decision when they need to.** As is clear from earlier sections, all possible and appropriate help and support must first be given to assist the person in making the decision. Part 2 only applies if all of this support has failed. This part involves four additional 'tests', the first three of which should be applied together – if a person cannot do any of these things they will be treated as unable to make a decision. The fourth can only apply to those people who cannot communicate their decisions in any way.	*Such a situation is uncommon and generally means the individual is unconscious, in a coma or has 'locked-in syndrome' where they are conscious but cannot move or speak at all.*
2.3.4	**Test 1: Understanding Information** No assessment of understanding should take place without being sure that the relevant information has been provided and in such a way that is most appropriate to helping the person to understand. This will be different to each person, should be tailored to their individual needs and documented appropriately. Communication (and documentation) must include: • The nature of the decision • The reason why the decision is needed • The likely consequences of making a decision or not making a decision	
2.3.5	**Test 2: Retaining Information** The information must stay in a person's mind long enough for them to be able to use it to make a valid decision. However, even if people can only retain information for a short time they should not automatically be assumed to lack capacity. Again it will depend on the decision in question and the tools that can be used to support a person.	*On asking the same questions after five minutes consistent responses should be given.*

2.0	PROCEDURE	*PRACTICE*
2.3.6	**Test 3: Using and weighing up information** It is not just enough to be able to understand or retain information – a person must also be able to consider it to form an effective judgement, including an understanding of the consequences of the decision.	
2.3.7	**Test 4: Inability to communicate** A complete inability to communicate is rare. However, in these circumstances the MCA is clear that a person should be treated as if they are unable to make that decision. As with other aspects of capacity, all attempts should be made (and documented in the case file) to help the person to communicate.	
2.3.8	**Best Interest** A decision may be made on behalf of a person who has been assessed as lacking the capacity, provided it is in their 'best interest'. The MCA enshrines good practice into law. It encompasses a process to follow that enables those working with a person who lacks capacity to gather evidence and arrive at a decision which has taken account of all the circumstances, one which reflects the person's wishes and is taken in their best interest. Chapter 5 of the CoP sets out a Best Interest Checklist. Health and Social Care staff are involved in a variety of decisions for people who may lack or have difficult with capacity. Such decisions can vary along a continuum from simple or information such as 'what to wear and what to eat…' to complex and high-risk decisions involving 'serious medical treatment, adult protection, mental health and deprivation of liberty…' It is therefore important to identify the appropriate individual to make the decision and the level of decision-	*The CoP states that: "The term 'best interests' is not actually defined in the Act. This is because so many different types of decisions and actions are covered by the Act and so many different people and circumstances are affected by it."* *Appendix Two shows a Best Interests Flow Chart*

2.0	PROCEDURE	*PRACTICE*
	making that is required at the earliest stage possible. This will ensure that the level of professional involvement and any relevant safeguards match the importance of the decision to be made. In all cases the decision-maker must consult with 'relevant others' – including those with lasting power of attorney, IMCAs, carers, family members. Some decisions may require a 'Best Interest Meeting' to be convened. This is to ensure that all views are taken into account, for example, where someone has lasting power of attorney, where an IMCA is involved or where there needs to be a multi-agency approach to the decision or action being taken. This allows for all relevant information to be presented and the person's wishes, feeling, values and beliefs to be explored as part of the decision-making process.	*Halton Borough Council may convene such a meeting on behalf of a person lacking capacity, or may be invited to such a meeting as a partner agency.*
2.3.9	**Levels of decision-making** **Informal or simple:** These are decisions involving a person's daily routine. For example, where to go, what to wear, what to eat, what to buy. **Decision-maker** – the person's direct carer in consultation with family, friends and/or relevant others. **Recording procedures** – A brief note included in case notes and/or care plan. Record whichever decisions (if any) the person can make for themselves and what is known about their preferences (food, clothes, etc.) **Significant or formal:** These are long-term decisions such as care planning/review or decisions in relation to serious or long-term treatment. Care reviews held within a residential setting should be carried out formally with capacity assessment and Best Interest plans being documented.	

2.0	**PROCEDURE**	***PRACTICE***
	Decision-maker – an allocated key worker, such as a social worker, community nurse, or other professional…in consultation with relevant others (staff, family, friends, relevant others). Consideration should be given to instruction of IMCA services (if no other relevant person is identifiable). Also on whether to hold a best interest meeting to consult all parties. **Recording procedures** – In-line with Halton Borough Council policies care management data should be recorded on CareFirst6. **Complex or high risk:** This may include decisions involving long-term accommodation or serious medical treatment. Decisions where risks are high could be those around adult protection, and/or cases involving an 'Urgent Authorisation' for a Deprivation of Liberty. There may be a lack of consensus between those involved in the decision-making that requires a more formal approach to be taken to assessment, consultation and recording. Frequently the opinion of more than one professional will be involved and care-planning decisions will generally be within a multi-disciplinary context. **Decision-maker** – Allocated key worker, social worker, social care or health manager, doctor as part of a multi-disciplinary team and including a Best Interest Assessor and legal advisor if needed. **Recording procedures** – as above in significant/formal decisions. Additional reports, second opinions, legal advice may be required. Include a safeguarding plan if needed.	
2.4	**Local Governance Arrangements, Data Management and Performance Measures** As far as practicably possible all policies and procedures for the MCA and DoLS have been aligned to ensure that systems of delivery are consistent.	

2.0	PROCEDURE	*PRACTICE*
2.4.1	**MCA Steering Group** An MCA Steering Group, formed in 2006, meets twice a year, to focus on local delivery of the Act. The group has representation from: • Council services across Adult Social Care • Halton Borough Council Legal Services • NHS Halton and St Helens • The residential provider sector • The Halton and Warrington NHS • The local IMCA service The agenda for the group centres on: • Development of policies and procedures • Development and implementation of effective information • Training • Development of the IMCA Service	
2.4.2	**CareFirst6** Care records (adults and children's social services) are kept by Halton Borough Council on the data management system CareFirst6. Interactions and contact with service users should be appropriately recorded on CareFirst6. This includes keeping records on any assessments of capacity and best interest decisions made.	*Appendix Three and Four sets out the fields for completion on CareFirst6 for Mental Capacity Assessment and for Best Interest decision-making.*
2.4.3	**Performance requirements** Application of the MCA is a statutory requirements and Halton Borough Council is monitored and measured on its performance against the legislation. Accurate documentation of assessments, decisions and actions is vital to ensure that the	*Some fields on CareFirst6 will be mandatory – these are often the data areas which*

2.0	**PROCEDURE**	***PRACTICE***
	Authority can be held accountable for its activities and contact with service users who may lack capacity. Staff should, as part of their induction, become conversant and competent in their use of the CareFirst6 data management systems.	*relate to performance data requirements.*
2.5	**IMCA Services** Under the Care Act 2014, the right to independent advocacy was extended. The duty to employ advocacy services falls under the conditions that the individual has 'substantial difficulty' in being involved and has no other 'appropriate individual' to represent or support them. Independent advocacy can be appointed to support any stage of assessment, care and support planning, during safeguarding enquiries and reviews or appeals against eligibility decisions around access to service. The role of the IMCA is different from other forms of advocacy and should be recognised as such by all health and social care organisations. Their aim is to ensure that 'all practical and appropriate support' is given to assist the individual lacking capacity to be involved as much as possible in the decision. Those who lack capacity have the right to independent advocacy where they have no one else to represent them. In some instances, Independent Mental Capacity Advocates may also be commissioned to support a carer or deferred decision-maker. IMCA services may be employed where decisions need to be made which impact significantly on the person's life. These include decisions about a change in accommodation (short or long-term); a serious medical treatment; an adult protection procedure; or a case review.	*As stated in Section 1.7.14.* *The role of the IMCA can be divided into two parts:* • *The traditional advocacy role supporting and representing a person's wishes and feelings so that they are fully taken into account; and* • *The role of providing assistance for challenging the decision-maker when the person lacking capacity has no one else to do this on their behalf.*
2.5.1	An IMCA will establish contact with the person deemed to lack capacity to help support the decision-making process. They will take action to	***An IMCA does not make decisions or assess capacity. They provide advice, assistance and***

2.0	PROCEDURE	*PRACTICE*
2.5.2	help the person: • Express their wishes, feelings, beliefs and values; • Secure their rights; • Have their interests represented; • Access information and services; and • Explore choices and options IMCAs may work with service-users who have verbal communication difficulties. Where possible other means of communication should be explored, including the use of picture or signs. Occasionally no direct communication is possible, in which case the IMCA must elicit as much as possible from relevant records and other people who know or knew the person. IMCA services are paid, commissioned through the local authority or NHS. Services may be co-commissioned across a number of authorities. Each individual IMCA working for an IMCA service must be approved to undertake the role by the commissioning authority and hold relevant experience and training. The role typically involves the following: • Provide statutory advocacy. • Support and represent people who lack capacity to make decisions on specific issues. • Meet in private with the person they are supporting. • Access relevant health and social care records. • Provide support and representation, specifically while the decision is being made. • Act quickly, so that their report forms part of the decision-making. • Obtain and evaluate information.	***representation.*** *Before an IMCA is appointed they are subject to checks with the Disclosure and Barring Service (DBS).*

2.0	PROCEDURE	*PRACTICE*
	• Represent and support the person so they may participate as far as possible in any relevant decision. • Ascertain as far as possible, the person's beliefs, values, wishes and feelings. • Select alternative courses of action. • Obtain a further medical opinion, if deemed necessary. • Resolve disagreements about health care, treatment or social care. • Challenge or assist in challenging the decision-maker by using existing complaints procedures. The right to challenge applies both to decisions about lack of capacity and a person's best interests.	
2.5.3	An IMCA will also be required in the following situations where additional safeguards are important: • Decisions that may involve the provision of serious medical treatment, or the withholding or withdrawal of such treatment by the NHS, but not treatment regulated under Part 4 of the Mental Health Act. According to the MCA, NHS bodies are duty bound to instruct an IMCA when they are proposing to take a decision about 'serious medical treatment' or proposing that another organisation (a private hospital) carry out treatment on their behalf. This duty applies if, either the person lacks the capacity to make the decision themselves or there is no one (friends or family) available to consult about the decision. • Decisions (by an NHS body or Local Authority) to move a person into long-term care in a hospital (for more than 28 days) or care home (for more than 8 weeks). This applies where the accommodation or move is not a requirement of the Mental Health Act 1983. The IMCA role also applies where individuals being moved are self-funding with care being arranged by the local authority.	*An IMCA must be engaged to support the person who lacks capacity at the earliest possible stage. The only exception to this is in situations where an urgent decision is required. If this is the case, the decision-maker must involve an IMCA as soon as possible after an emergency decision is made, if:* • *The person is likely to stay in hospital for longer than 28 days; or* • *They will stay in other accommodation for longer than eight weeks.* *Where the person is detained or required to live in accommodation under the Mental Health Act, an IMCA will not be needed, since the safeguards under that Act will apply.*

2.0	PROCEDURE	*PRACTICE*
	• Decisions (by an NHS body or local LA) to move a person into a different hospital or care home. This applies where the current accommodation or move is not a requirement of the Mental Health Act 1983. Again, the IMCA role also applies where individuals being moved are self-funding with care being arranged by the local authority. • Local Authorities and NHS bodies may also involve an IMCA in a care review involving a change of accommodation. This applies where the individual has been in present accommodation for at least 13 weeks and the change in accommodation is being considered or arranged by the Local Authorities or NHS body.	
2.5.4	In undertaking this role, the IMCA will: • Be independent (impartial and objective) of the person making the decision. • Provide support for the person who lacks capacity. • Represent the person without capacity in discussions to work out whether the proposed decision is in the person's best interests. • Provide information to help work out what is in the person's best interests. • Raise questions or challenge decisions which appear not to be in the person's best interests. • Take responsibility for declaring any personal interest in a case and withdrawing from a referral to a person they have an established relationship with. Where the IMCA and the decision-maker(s) disagree, discussion and negotiation should be used to settle the disagreement. If this is not possible then the relevant complaints procedure (of the organisation employing the decision-maker) should be followed. Where no resolve can be sought the decision may be referred to the Court of Protection.	

2.0	**PROCEDURE**	***PRACTICE***
2.5.5	**IMCA – Safeguarding and Adult Protection:** Local Authorities and NHS bodies may also involve an IMCA in adult protection cases, where it is alleged the person is or has been abused by another, or is abusing or has abused another. This means that if they lack capacity, both victims and perpetrators can benefit from the support of the IMCA service**.** The involvement of an IMCA in such situations is a power rather than a duty. Local Authorities and NHS bodies which instruct an IMCA for adults at risk are legally required to give consideration to any representations made by the IMCA when making decisions concerning protective measures. Regulations allow IMCAs to make representations on any matter they feel is relevant to such decisions. For example they may raise concerns about the investigative process or the involvement of the police. IMCAs are required to produce a report for the person who instructs them. This should include representations regarding the proposed protective measures and any matters the IMCA feels are relevant.	*Where the person who instructed the IMCA is not the Safeguarding Manager (SM), SCIE recommend that a copy of the report is sent to the SM. Good practice is for the Safeguarding Manager to decide on the distribution of the report and not the IMCA. If asked for copies of the report the IMCA should direct the person to the SM.*
2.6	**The Court of Protection** The Court of Protection was created as a superior (specialist) court of record under the MCA. It has the same powers, rights, privileges and authority as the High Court. As such it can establish precedence and build up expertise in all matters related to the lack of capacity. As stated in Section 1.7.9 it was set up to deal with decision-making for adults (and some children) who may lack capacity to make decisions for themselves. It deals with decisions about finance and property but also about healthcare and personal welfare	*Prior to 2007 the Supreme Court of England and Wales dealt with matters of property and affairs of those who lacked capacity.* *Previous arrangements under the Supreme Court did not*

2.0	PROCEDURE	*PRACTICE*
	matters. It can appoint deputies to make decisions for people who lack capacity to make decisions for themselves. It is also used to decide whether an LPA (or EPA) is valid and where necessary, can remove deputies or attorneys who have failed to carry out their duties.	*deal with healthcare or personal welfare.*
2.6.1	It is expected that decisions are reached without referral to the Court, however it may be necessary to apply to the Court for: • Particularly difficult decisions. • Disagreements about capacity and best interest that cannot be resolved in any other way. • Situations which need ongoing decisions about an individual's personal welfare. • Contact issues with family where a restriction is being considered.	*Fees may be applicable to applications made to the Court of Protection.* *Application to the Court can come from any interested party, in accordance with the circumstances of the application. If a serious or major decision about treatment needs to be made then the application may come from the NHS Trust. It can also be from a family member as a means of settling a disagreement. The person being assessed can apply to the Court to challenge a decision that they lack capacity.*
	Within Halton Borough Council staff should refer matters of concern to their Divisional Manager, who will take advice from Legal Services prior to an application being made to the Court of Protection. Informal discussions to resolve any disputes should always be made prior to escalation.	*Service users, carers, families and other interested parties should be made aware of Halton Borough Council's Adult Social Care Complaints Procedure as a means of resolving disputes.*
2.6.2	It will usually be necessary to refer matters to the Court relating to property and affairs (including financial matters) of a person who lacks capacity, unless: • Their only income is state benefits. • They have previously appointed a deputy as part of a LPA (or EPA).	
	The Court of Protection has powers to make decisions on specific issues such as serious	*If an individual disagrees with a ruling of the Court of*

2.0	**PROCEDURE**	***PRACTICE***
	medical treatment. This includes: • Decisions about the proposed withholding or withdrawal of artificial nutrition and hydration for people in a permanent vegetative state. • Cases involving organ or bone marrow donation by a person who lacks capacity to consent. • Cases involving non-therapeutic sterilisation of a person who lacks capacity to content to this. • All other cases where there is doubt or dispute about whether a particular treatment will be in a person's best interest.	*Protection they have the same right of appeal as they would with any High Court decision. Advice should be sought from a solicitor.*
2.7	**Supporting Carers** The Care Act 2014 provides statutory rights for carers to have their own care and support needs assessed and where eligible, provided for. This may be in situations where the carer finds the caring role has significant impact on their health or wellbeing. This right may be appropriate for those who undertake the role of attorney or guardian for a person who lacks capacity. Provision may include the right for an RPR (Relevant Person's Representative), within a DoLS arrangement, to access IMCA services in support of their role in representing the person who lacks capacity and has been deprived of their liberty.	*Carers are first point of contact would normally be through the IAT (Initial Assessment Team).* *Instigation of IMCA support for an RPR will be made via the Integrated Adult Safeguarding Unit (IASU).*
2.8	**Learning and Development Needs** All staff working in the fields of Health and Social Care should have a firm understanding of the MCA. A detailed local plan for meeting learning and development needs (in relation to MCA) has been devised with a range of training options and access points available to Council staff involved	*The Mental Capacity Act Learning Pathway (Appendix Five) has been developed to give clear direction on the*

2.0	**PROCEDURE**	***PRACTICE***
	with services users who may lack capacity. This ranges from general awareness and overview training, to much more specific issues required by those who assess capacity, to specialist training for Best Interest Assessors in DoLS arrangements.	*training requirements dependant on the level of interface with the service-user.*
2.9	**Further considerations**	
2.9.1	**Multi-agency/multi-disciplinary working** The integration of health and social care was further embedded through legislative reform in the shape of the Care Act 2014. Increasingly multi-disciplinary working is being developed to assure the welfare and wellbeing of the service user in a holistic way. This requires Local Authority and NHS professionals working together, sometimes under pooled budgets or within integrated teams, to achieve defined outcomes. Additionally, multi-agency working, across the public, private and voluntary sector is common-place. This allows for services to be delivered in innovative and cost-effective ways and also for greater choice for the service user. Working in the best interest of the service user is paramount to multi-disciplinary and multi-agency working. Transparency of action and decision, in the form of effective and process-driven documentation, is essential to ensuring co-operation and consistency of practice. Successful communication in multi-agency and multi-disciplinary working practice is also a key consideration to safeguarding. The protection of vulnerable adults, such as those who lack capacity to make decisions for themselves, is the responsibility of all agencies and organisations involved in the care and treatment of that person.	*All agencies and organisations should abide by data protection laws as well as taking account of their own policies and procedures in relation to information governance.*
2.9.2	**Fluctuating Capacity** Certain conditions, illness or disability may leave a person with fluctuating, or temporary, capacity.	*Dementia poses a common dilemma in relation to*

2.0	PROCEDURE	*PRACTICE*
	This poses a difficulty for professionals involved in a person's care and treatment in ensuring that the Principles of the MCA are applied appropriately. Here, there may need to be a focus on 'decision specific' assessment of capacity. It is also permissible, where capacity fluctuates, to delay decisions, where time allows, and/or assessment of capacity. Documenting a decision made during a period of 'compos mentis', along with the person's wishes and feelings were they to lose capacity following the decision made, serves a useful purpose here. A Deprivation of Liberty Safeguard may be appropriate for someone who lacks capacity and needs to be under continuous supervision and control. However, where someone is likely regain capacity but there is evidence that they would object to admission and/or treatment the MHA needs be considered, providing they meet the criteria for detention under this Act. DoLS cannot be used if the patient is objecting to admissions and/or treatment and has the capacity to object.	*fluctuating capacity and assessment may need to be made on a decision-by-decision basis.* *Referral to the Court of Protection may be required where agreement cannot be reached in such cases.* *This may be setting specific dependant on what the admission is for and the treatment proposed.* *See also: DoLS Code of Practice.*
2.9.3	**Changes to legislation and the impact of Case Law** The reach of the MCA is immense and the balance it seeks to strike between protection and autonomy can be seen as precarious. Application of the MCA in practice presents philosophical, ethical and moral challenges which can be borne out in case law. More recently (2014) the Supreme Court judgement ("P v Cheshire West and Chester Council and another" and "P and Q v Surrey County Council") has widened the threshold for DoLS authorisation. Legislative reform to DoLS provision is currently under review by the Law Commission. The Care Act 2014 represents the most significant piece of legislative reform for adult social care in 60 years; it codifies various laws and sets out new	*This is evidence from the 'Bournewood' judgement and the subsequent incorporation of Deprivation of Liberty Safeguards in the MCA in 2009.* *Appropriate review will be made of relevant policies as required by legislative reform.*

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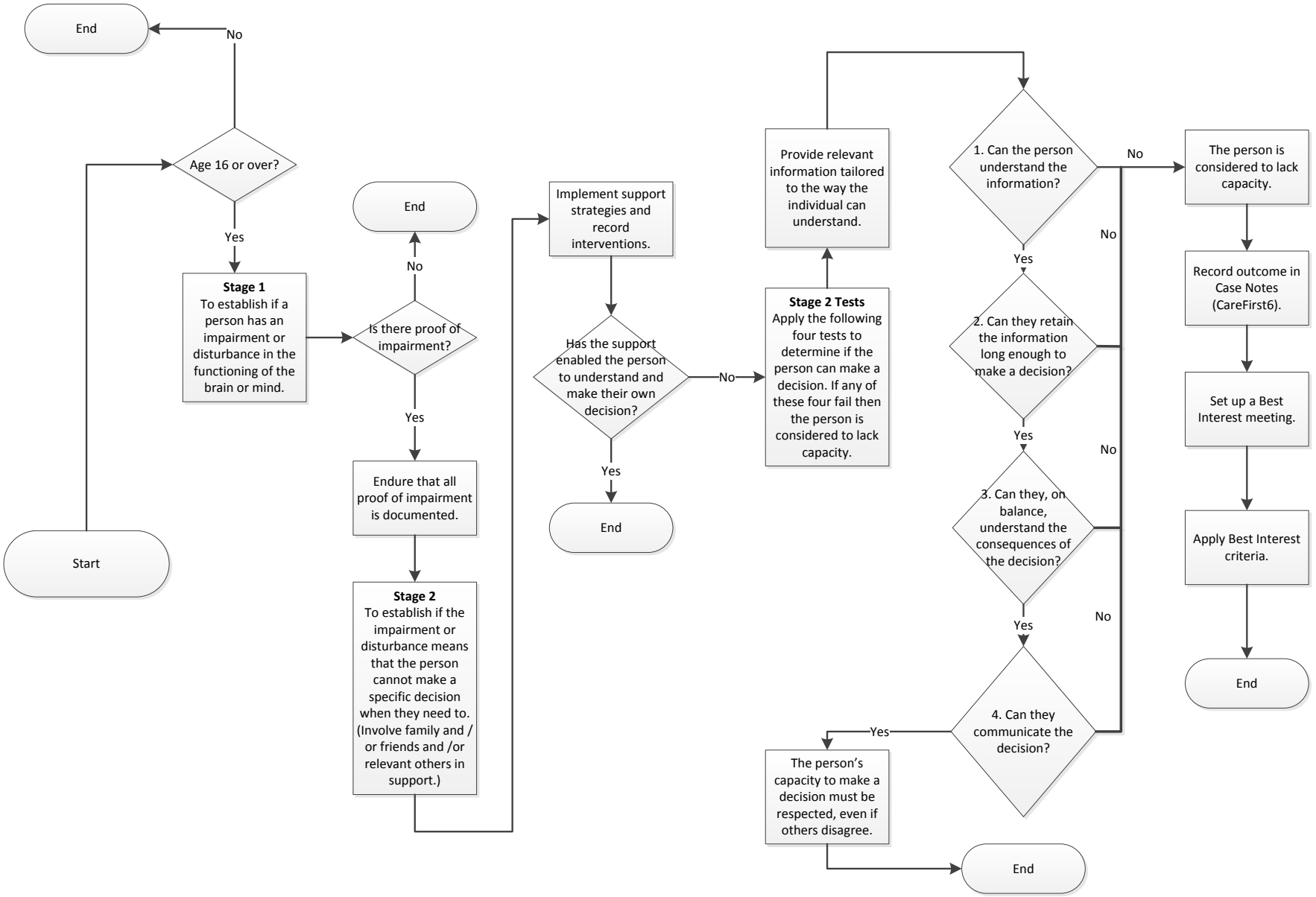
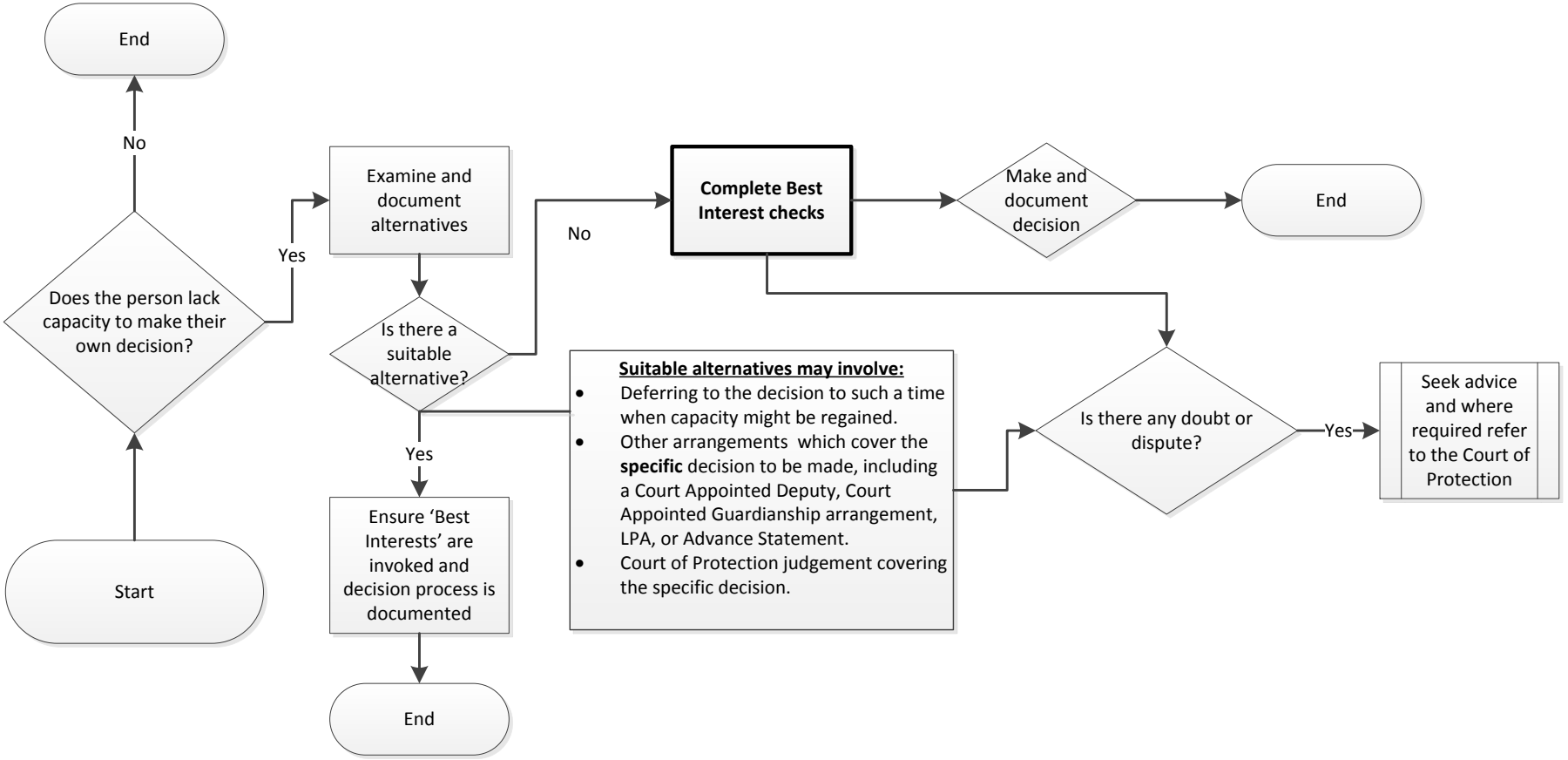
	statutory requirements for Local Authorities. Areas which may impact on application of MCA provision and services include: • New rights for carers to be recognised in the same way as those they care for. • New safeguarding duties, guided by the principles of empowerment, prevention, proportionality, protection, partnership and accountability. • New duties to provide advocacy, including, where needed, for carers (including Relevant Person's Representatives in DoLS). • Definition and responsibility under the concept of 'ordinary residence'.	
	It is important for practitioners to remain conversant with changes to statute and judicial decisions, in the form of case law, which may impact on application of the MCA. This allows for effect, appropriate and evidence-based decision making to be applied in practice.	*This should be undertaken as part of continuing professional development (CPD) and cascaded to colleagues as appropriate.* *Major changes will be represented in policy reviews.*
2.9.4	**Limitations to the MCA** The MCA covers a range of decisions and actions which can be made or taken in a person's best interest. Where agreement cannot be reached about 'best interest' decisions may be referred to the Court of Protection. Some decisions are not included as they are considered so personal to the individual concerned, or are governed by other legislation. There are some decisions that automatically require a ruling from the Court of Protection.	*Sections 27-29 and 62 of the MCA set out the specific decisions which can never be made or actions which can never to carried out under the Act. 'Advance Decisions' may override the need to gain permissions from the Court of Protection provided they are legitimate.*

MENTAL CAPACITY ASSESSMENT FLOW CHART



APPENDIX TWO

BEST INTERESTS FLOW CHART



APPENDIX THREE

CareFirst6 Data Fields for Mental Capacity Assessment

Mental Capacity Assessment	
Form Details	
Form Start Date:	Worker Name:
Person Details	
Name:	CareFirst ID:
DoB/EDD:	Gender:
Address:	Tel No:

Important Information
Deciding that a person lacks capacity is a serious step. This pro-forma provides a means of structuring and documenting in a formal and clear way, the information required by those who are involved in assessing capacity.
Inc. staff working in health & social care (doctors, nurses, dentists, psychologists, psychiatrists, therapists, social workers, residential & care home managers, care staff, support workers) as well as carers, families, advocates & probation staff.
Assessing Capacity -- This needs to be integrated into the usual assessment procedures, care planning, reviews and monitoring. For some staff it will become part of the single assessment process (SAP).For others it may be part of reviews & monitoring
Unwise decision -- A person who has capacity can make an unwise decision. Hence, if an individual makes an unwise decision, this does not of itself indicate that they lack capacity.
Two-stage test -- The following two-stage test must be applied when assessing capacity. This pro-forma record provides the documentary evidence that it has been used.
1. Is there an impairment of, or disturbance in the functioning of the person's mind or brain? 2. If so, is the impairment or disturbance sufficient that the person lacks the capacity to make that particular decision?
Please refer to Mental Capacity Act guidance. (See Mental Capacity Act guidance) Please refer to the Mental Health Act Procedures Manual.

Assessment
What is the decision?
Date(s) of previous Mental Capacity Assessment(s)
STATUS DATE CORRESPONDS TO THE DATE DECISION WAS MADE
Assigned To: Date: Activity Type: Child Visit? Child Seen Alone? Details:
Date of this Mental Capacity Assessment
STATUS DATE CORRESPONDS TO THE DATE THE DECISION WAS MADE. PROVIDE BRIEF DETAILS OF THE DECISION TO BE MADE AND THE OUTCOME OF THIS ASSESSMENT IN THE NOTES FIELD

Mental Capacity Assessment	
Name:	CareFirst ID:

Assigned To: Status: Status Date: Requested Date: Required by Date: Priority: Details:
Details of the person's Next of Kin
Relationship: Name: Address: Email: Phone: Notes:
Nearest relative (under the Mental Health Act)
Relationship: Name: Address: Email: Phone: Notes:
Details of the person with a Lasting/ Enduring Power of Attorney
Relationship: Name: Address: Email: Phone: Notes:
Details of the Independent Mental Capacity Advocate
Relationship: Name: Address: Email: Phone: Notes:

Mental Capacity Assessment	
Name:	CareFirst ID:

Details of the Court of Protection Deputy
Relationship: Name: Address: Email: Phone: Notes:
Details of the Supporting Clinician (if applicable)
Relationship: Name: Address: Email: Phone: Notes:
Details of other significant professional relationships
FOR EXAMPLE GP, CARE HOME STAFF, ETC…..
Name: Relationship: End Reason: Address: Email: Phone: Notes:

Examples of Impairment Conditions that are associated with Mental Capacity are:	
Dementia, significant learning disabilities, long term effects of brain damage, physical or mental conditions that cause confusion, drowsiness or loss of consciousness, delirium, concussion, symptoms of drug or alcohol abuse.	
In addition, there are a number of disease processes and conditions, which although temporary, can also affect capacity.	
Stage One	
Does the person have an impairment condition or disturbance in the functioning of their mind or brain?	
THE APPROPRIATE GUIDANCE SHOULD BE CONSULTED WHEN ESTABLISHING WHETHER THE PERSON HAS AN IMPAIRMENT CONDITION OR DISTURBANCE IN THE FUNCTIONING OF THEIR MIND OR BRAIN.	
If YES, provide details of all proof of impairment.	
WITHOUT PROOF A PERSON IS CONSIDERED TO HAVE CAPACITY UNDER THE ACT.	

Mental Capacity Assessment	
Name:	CareFirst ID:

If no, the assessment can be ended at this point – proceed to question 2.1.25
Stage Two
Obtain assistance from professionals and family members to establish that an impairment or disturbance means the person cannot make a specific decision when they need to.
Family members and professionals can assist considerably by providing important background information. They can provide evidence to show that some temporary disease process or condition is affecting capacity.
Such temporary infections or conditions may persist for 6 months or more, after which capacity may be regained with support.
Provide details of those who are providing assistance and background information
Include details of any temporary condition(s) that is affecting capacity
Provide details of support strategies that will be implemented

Has the implemented support worked?	

IF YES, THE PERSONS CAPACITY TO MAKE A DECISION MUST BE RESPECTED AND THE ASSESSMENT CAN BE ENDED - PROCEED TO QUESTION 2.1.25
If NO, please provide details of why interventions / support have failed
If support has failed then the following four tests must be carried out to determine if the person can make a decision and are crucial in demonstrating a lack of capacity.
Information relevant to each of the tests must be tailored as far as possible to the way that the individual can understand and communicate. For example the use of pictures, signing, Braille, an interpreter.
If any single test is failed, then the person is deemed not to have capacity.
Test One

Can the person understand the information relevant to the decision?	

IF NO, COMPLETE QUESTION 2.1.18 AND PROCEED TO QUESTION 2.1.25.
Evidence of level of understanding of information relating to the decision

Mental Capacity Assessment	
Name:	CareFirst ID:

Test Two	
Can the person retain the information?	
IT MUST STAY IN THEIR MEMORY LONG ENOUGH TO ENABLE THEM TO MAKE A VALID DECISION. IF NO, COMPLETE QUESTION 2.1.20 AND PROCEED TO QUESTION 2.1.25.	
Evidence of level of information retention concerning the decision	
Test Three	
Can the person use that information as part of the decision making process or appreciate the consequences of the decision in the sense that they can weigh its importance?	
IF NO, COMPLETE QUESTION 2.1.22 AND PROCEED TO QUESTION 2.1.25.	
Evidence of ability to weigh importance and consequences of decision	
Test Four	
Can the person communicate the decision, whether by talking, using sign language or any other means?	
ALL ATTEMPTS SHOULD BE MADE AND DOCUMENTED TO HELP THEM TO COMMUNICATE. IF NO, COMPLETE QUESTION 2.1.24 and proceed TO QUESTION 2.1.25.	
Evidence of ability to communicate decision	
Capacity Decision	
Does the person have the capacity to make the decision detailed in this document?	
If YES and the individual is found to have capacity to make a decision, then their decision must be respected and no further action is required. If NO, proceed to question 2.1.26. *THIS QUESTION IS MANDATORY*	
If capacity is found to be lacking, complete the Best Interest Decision process before deciding what is best for the person. Is a Best Interests Decision form required?	
HINT - SELECTING YES WILL ASSIGN A BEST INTEREST DECISION FORM TO YOU FOR COMPLETION	
Completion	
Completed by: Worker: Tel: Address:	Date:

APPENDIX FOUR

CareFirst6 Data Fields for Best Interest Decisions

Best Interests Decision

Form Details	
Form Start Date:	**Worker Name:**

Person Details	
Name:	**CareFirst ID:**
DoB/EDD:	**Gender:**
Address:	**Tel No:**

Important Information
This pro-forma provides a means of structuring and documenting the information required by those participating in making decisions and working in the best interests of adults lacking capacity.
This includes staff working in health and social care (doctors, nurses, dentists, psychologists, therapists, social workers, residential and care home managers, care staff, support workers) as well as carers, families and advocates.
Best Interests - When we make a decision on behalf of someone who lacks capacity, it must be the best one for that person, not us!
Least Restrictive Alternative - Different options and choices may be available. Before making the final choice all other less restrictive options for the person should be considered and where possible chosen.
The choice made should avoid placing unnecessary restrictions on the person's future opportunities, but still allow the original purpose of the decision to be made.
Please refer to Mental Capacity Act guidance. (See Mental Capacity Act guidance) Please refer to the Mental Health Act Procedures Manual. (See Mental Health Act Procedures Manual)

Best Interests Decision
What is the decision?
Date(s) of previous Mental Capacity Assessment(s)
Status date corresponds to the date the decision was made.
Assigned To: **Date:** **Activity Type:** **Child Visit?** **Child Seen Alone?** **Details:**

Best Interests Decision	
Name:	CareFirst ID:

Date(s) of previous Best Interest Decision(s)
STATUS DATE CORRESPONDS TO THE DATE THE DECISION WAS MADE.
Assigned To: **Date:** **Activity Type:** **Child Visit?** **Child Seen Alone?** **Details:**
Date of this Best Interests Decision B
STATUS DATE CORRESPONDS TO THE DATE THE DECISION WAS MADE. PROVIDE BRIEF DETAILS OF THE DECISION TO BE MADE AND OUTCOME OF THIS ASSESSMENT IN THE 'NOTES' FIELD
Assigned To: **Status:** **Status Date:** **Requested Date:** **Required by Date:** **Priority:** **Details:**
List all individuals attending the meeting and their current position:

	Name	**Position**	**Contact Number**	**Role/ Relation to Service User**
1				
2				
3				
4				
5				
6				

If the matrix above is full please continue in the text box below
If a person demonstrably retains capacity then their decision must be respected. If they lack capacity then evidence must be provided.
Provide details of the evidence gathered

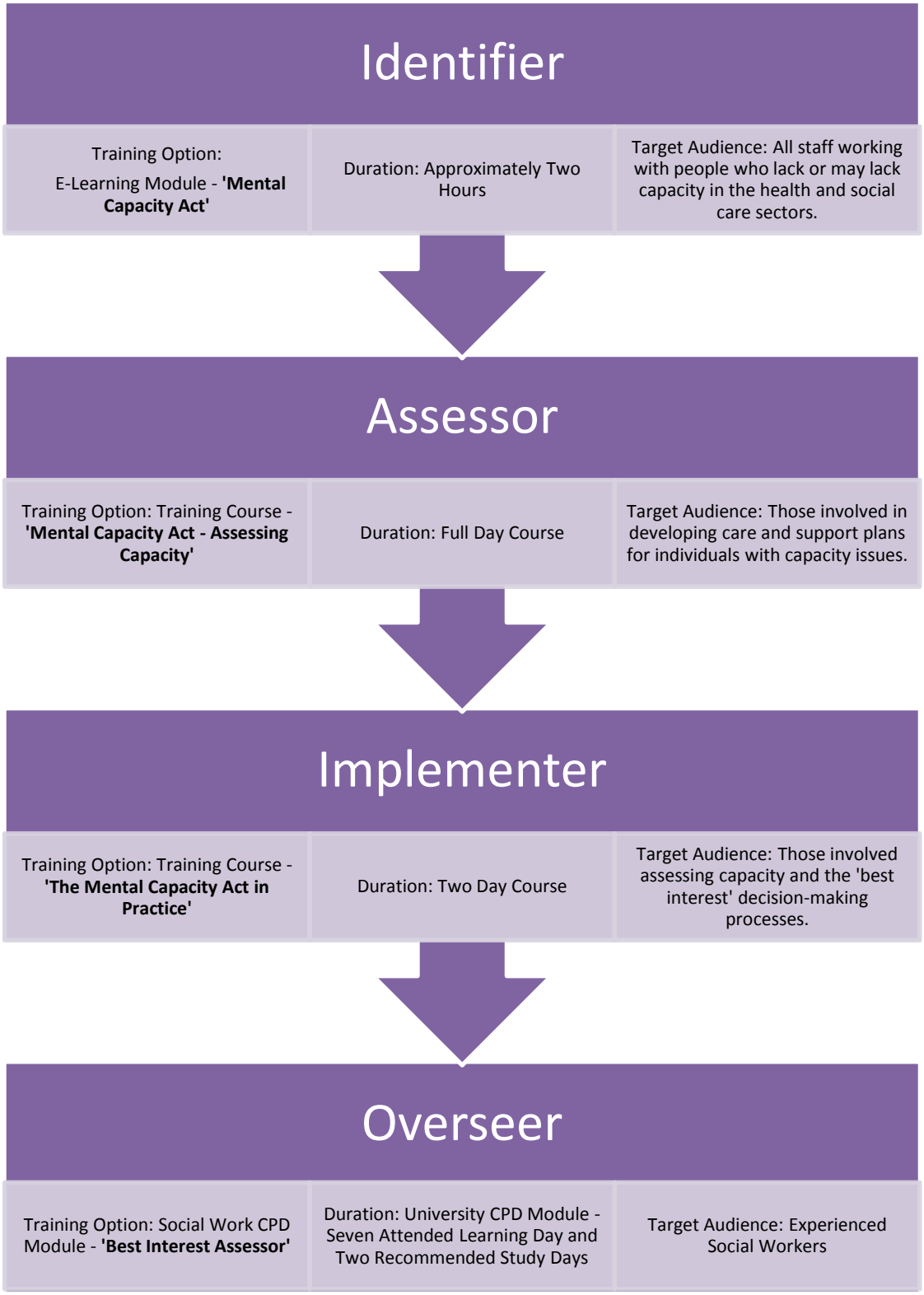
Best Interests Decision	
Name:	CareFirst ID:

Provide evidence that potential alternatives to the decision to be made have been thoroughly examined and appropriately documented. If a suitable alternative is found this should be identified as such. If no alternative then go to 2.1.9.	
PROVIDE DETAILS OF THE LEAST RESTRICTIVE OPTIONS BELOW	
If the text box above is full please continue in the text box below	
Identify a suitable individual who is both willing and able to be consulted on behalf of the person. If no one suitable can be found from among friends and family then contact the Independent Mental Capacity Advocacy (IMCA) service, go to 2.1.10	
PROVIDE THEIR NAME AND CONTACT DETAILS BELOW	
Are there any arrangements with the Court of Protection (COP), relating to the decision? COP now cover issues of health and wellbeing, in addition to accommodation and finance.	
IF THERE IS, PLEASE FOLLOW COP GUIDANCE. IF NO SUCH ARRANGEMENTS IN PLACE, PLEASE GO TO 2.1.11 BELOW.	
Is the decision connected to the care and treatment of the person?	
IF NO, THEN SEEK ADVICE FROM THE PUBLIC GUARDIAN AND PROCEED TO QUESTION 2.1.16. IF YES, PROCEED TO QUESTION 2.1.12 AND CHECK FOR EVIDENCE OF AN ADVANCE STATEMENT (ALSO KNOWN AS: LIVING WILL, ADVANCE DECISION OR ADVANCE DIRECTIVE).	
Details of Advance Statement	
IF THERE IS NO RELEVANT ADVANCE STATEMENT, PLEASE CHECK IF THERE IS A LASTING POWER OF ATTORNEY AND PROCEED TO QUESTION 2.1.17.	
Is the Advance Statement in agreement with clinical judgement?	
If YES, please provide evidence below	
If NO, proceed to question 2.1.18 and complete 'Best Interest Checks'	
If YES to 2.1.13, are there any doubts about the Advance Statement?	
IF YES, PLEASE COMPLETE THE 'BEST INTERESTS CHECKS' - 2.1.8. IF NO, THEN THE ADVANCE DIRECTIVE THAT HAS BEEN MADE WHILE THE INDIVIDUAL WAS CAPABLE, IS LEGALLY BINDING.	
Is a decision needed from the COP?	
IF YES, PLEASE FOLLOW COP GUIDANCE AND END. IF NO, PROCEED TO QUESTION 2.1.17.	
Has a Lasting Power of Attorney (LPA) been identified?	
IF YES, THEN REFER TO INDEPENDENT MENTAL CAPACITY ADVOCATE (IMCA) AND GO TO 'BEST INTEREST CHECKS' - QUESTION 2.1.18. IF NO, PROCEED DIRECTLY TO 'BEST INTEREST CHECKS' QUESTION 2.1.18.	

Best Interests Decision	
Name:	CareFirst ID:

Best Interest Checks	
Describe how the individual has been encouraged to participate	
Document the person's views and wishes	
Is capacity likely to be regained?	
PLEASE NOTE THAT 'N/A' STANDS FOR 'NOT ANSWERED' NOT 'NOT APPLICABLE'	
If YES, please provide details and document decision to delay	
If capacity is NOT likely to be regained, give details and list all individuals who have been consulted about the person's welfare	
Make a decision in the best interests of the person, using the least restrictive options available. Always encourage the person to participate - avoid restricting their rights and do not make assumptions about their quality of life.	
Document any information that may contribute to the person's Best Interests and any possible conflicts of interest	
Provide details of the decision that has been made and its likely outcome	
Will a further Best Interests Decision form need to be completed?	
HINT - SELECTING YES WILL GENERATE A BEST INTEREST DECISION FOR	
Completion	
Completed By: **Worker:** **Tel:** **Address:**	**Date:**

Mental Capacity Act – Learning Pathway for Adult Social Care Staff



Identifier

E-learning chapters:

- Supporting people to make their own decisions
- Making day-to-day decisions about care and support
- Best Interest Decisions about day-to-day care and support
- Making more complex decisions
- More complex Best Interest Decision-making
- What to do when there is a disagreement
- Planning for the future
- A guide to the Deprivation of Liberty Safeguards
- Interface between the MCA and MHA

Accessing the Learning: The Council e-learning platform is situated on the 'Enable – Learning Pool' site which accessed through the intranet or via the Council's internet site. Contact Learning and Development regarding any access issues.

Assessor

Course objectives:

- To recognise the guiding principles of the Mental Capacity Act and understand why it is required
- To revisit the concept of 'duty of care' and how it relates to the Mental Capacity Act 2005, and Code of Practice
- To better appreciate person-centred care, and the need to deliver consistent and coherent, services which respect and protect Human Rights
- To be aware of the Agency documentation, check list, and to identify the relevant knowledge and skills required for assessing Best Interests decisions, in complex situations of competing demand
- To pinpoint the interface between the Mental Capacity Act 2005 and the Mental Health Act 2007
- To better develop strategies and skills in assessing and testing capacity, and ethical recording with the use of the agency pro forma

Accessing the Learning: This training course is available on the 'Corporate Learning and Development Calendar' and can be identified as a learning need in supervision discussions or as part of the EDR process. Where course dates are not available please contact Learning and Development.

Implementer

Course objectives:

- To examine capacity assessments in practice, considering when to assess, how to assess and what outcomes this will result in
- To take part in simulation assessment opportunities in a safe and developmental environment
- To explore the recording and reporting requirements involved in assessing capacity
- To be skilled in supporting people to make their own decisions, and recognising the IMCA role
- To recognise and response appropriately and with sensitivity to advance refusals and lasting powers of attorney
- To gain confidence in dispute resolutions skills resulting from conflict within the MCA process
- To understand the process and need for apply for Deprivation of Liberty Safeguards

Accessing the Learning: This training course is available on the 'Corporate Learning and Development Calendar' and can be identified as a learning need in supervision discussions or as part of the EDR process. Where course dates are not available please contact Learning and Development.

Overseer

Module Content:

The training will equip practitioners with the knowledge and skills necessary to undertake the role of the Best Interests Assessor under the Deprivation of Liberty Safeguards. The module teaching is underpinned by the key principles of the Mental Capacity Act 2005. It will also focus on human rights issues, and enable practitioners to develop their decision making skills in a range of complex practice situations.

Day	University Sessions
1	Introduction to the module and University systems Introduction to the Deprivation of Liberty Safeguards Human Rights Legislation
2	Mental Health Legislation ***Please note –AMHPs are not required to attend this session***
3	Mental Capacity Act 2005 and MCA Code of Practice Assessing capacity and best interests decision-making
4	DOLS Framework and Authorisation Process
5	Role and responsibilities of the Best Interests Assessor under DOLS Case Law
6	Practice Scenarios and documentation Input from practitioners
7	Case Scenarios and Assignment workshop

Accessing the Learning: This module is open to 'Experienced Social Workers', as set out in the 'Adult Social Care Social Work Progression Policy'. Applications should be made, in the first instance, through line management.

APPENDIX SIX

Quick Guide to: The Mental Capacity Act

The 5 Principles of the Mental Capacity Act:

1. A person must be assumed to have capacity unless it is established that he lacks capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him 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 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 best interests.
5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

Assessing capacity involves a two-stage test:

1. 'Does the person have impairment or a disturbance in the functioning of the mind or brain?'
2. 'Can the person make the relevant decision or not?' This is established by whether they can:
    a. Understand the information relevant to the decision,
    b. Retain that information,
    c. Use or weigh that information as part of the process of making the decision, or
    d. Communicate his decision (whether by talking, using sign language or any other means).

Where a lack of capacity is established **'Best Interest'** decisions may be made on behalf of a person. Best Interest involves consideration of all relevant circumstances, every possible and practicable effort to involve the person in the decision, taking account of the person's wishes and feelings, their values and beliefs, and consulting with their family, friends or relevant others.

Prior to losing capacity a person may appoint a deputy, under a **Lasting Power of Attorney**, to act on their behalf should they subsequently lose capacity.

Dispute about any decisions can be referred to the **Court of Protection** where no resolve can be reached informally.

A **Deprivation of Liberty Safeguard** arrangement may be made where a person lacks capacity to make decisions for themselves and it is in their best interest to detain them or make them subject to constant supervision and control. Deprivation of Liberty Safeguard can only be made according to well-defined processes.

A person suffering a mental health disorder may be detained under the **Mental Health Act** where it is in the interest of their own health and safety or with a view to the protection of others.