The Mental Capacity Act is relevant to us as professionals and as members of the public.

Its purpose is to clarify what is meant by capacity to make decisions and it sets in law a set of principles to be followed when it is necessary to make a decision for another person.

The Act establishes protections for such people and allows for people to choose who should make decisions for them in the future and how decisions should be made.

Professional staff in social care teams will be dealing with issues of mental capacity in relation to service users on a daily basis. As members of the public many of us will know people whose ability to make their own decisions is limited or declining. People with dementia are the most obvious example but anyone whose mental abilities are impaired – head injuries, strokes, learning disabilities, mental illness – temporarily or permanently, may find some decision-making difficult.

***The principles of the Mental Capacity Act***

1. Assume capacity
2. Assist the person to make their own decision
3. An unwise decision should not be taken to indicate a lack of capacity
4. Decisions made for a person who lacks mental capacity must be in their best interests
5. Any action taken for a person who lacks mental capacity must be the least restrictive way of addressing the situation

***What is mental capacity?***

The Act says that in order to make a decision any person needs to be able to do all of the following:

* **Understand** the relevant information – only the basics. More complex decisions will involve more detailed information
* **Retain** the relevant information long enough to be able to think about it and make a decision
* **Weigh** up the advantages and disadvantages of available options
* **Communicate** the decision to whoever needs to know

A person who cannot do **all** of these is regarded as lacking capacity but only in relation to this particular decision at this specific time. A statement that Mrs A ‘lacks capacity’ is not meaningful on its own. ‘Mrs A is able to make most basic daily decisions – what to eat or wear – but lacks capacity to make more complex decisions such as what care she needs or where she should live’ – a more precise statement.

People may be able to make some decisions but not others. This is because some decisions are much simpler than others.

***Best interests***

The Act says that to make a decision in a person’s best interests, whoever is making it needs to fully understand the person’s wishes and those of others involved. They must weigh up all relevant information, such as what care the person is assessed to need, and what options are available. In effect they need to try and work out what decision the person would make if they could make it. This can be difficult because the person may have lost their ability to communicate their wishes well. It is really helpful if people have written their wishes down when they were able.

People providing care to a person whose ability to make decisions is limited will need to make decisions for them. The decisions a family carer might make for a relative do not need to have detailed assessments and documentation. The Act says that people can work on the basis of having a ‘reasonable belief’ that the person they are caring for is unable to make the decision and that they are acting in their best interests.

A care worker in a care home will need to rely upon a written care plan which describes what assistance the person needs with making decisions.

A social worker involved in assisting a person who may need to move into a care home must do a detailed assessment of the person’s mental capacity and follow a more detailed best interests process. This is described in the recently published guidance (link below). The process needs to be more detailed and based upon thorough assessment because it may be necessary to make a decision which the person does not like. If their disagreement – or any disagreement by a member of their family – about what decision should be made, cannot be resolved, the Court of Protection can be asked to reach a conclusion.

***Protections provided by the Mental Capacity Act***

* Lasting Power of Attorney (LPA) – *created when a person has capacity* to choose who they want to make decisions for them if they lose capacity in the future. LPAs can be created for financial decisions and for health and welfare decisions. Anyone holding an LPA must act in the person’s best interests. They can’t refuse to pay for the care the person needs.
* Court Appointed Deputy – for financial or welfare decisions but the person wanting to make decisions applies to the Court for authority if the person concerned has already lost capacity. SCC’s client finance team act as Deputy for the finances of some service users.
* Independent Mental Capacity Advocate (IMCA) – an independent person to be consulted by a hospital or by a Local Authority if a major decision is needed – serious medical treatment or a move of accommodation – and the person who lacks capacity doesn’t have family or friends to be consulted.
* Court of Protection – makes decisions about mental capacity and best interests when there is a dispute which can’t be resolved. For major decisions only. The CoP might be asked to make a decision if a hospital thinks it is in a person’s best interests to stop treating them and allow them to die but their relatives do not agree. Or if SCC wants to place a person in a care home and the person is refusing to co-operate.
* Advance decisions to refuse treatment (ADRT)– a person who has capacity can decide that if in the future they lose mental capacity and become unwell there are certain treatments they would not want to be given. The person would write this document with their doctor but it does need to be quite specific about what treatments and under what circumstances. Note it is only a decision to refuse – not to request – treatment. This is because even if we have capacity the decision about what treatment to offer is made by the doctor not the patient. ADRT, if specific enough, is legally binding upon the treating doctors.

DNAR – do not attempt resuscitation – is a sort of ADRT. With capacity you can decide that if your heart or breathing stops you do not want anyone to attempt to resuscitate you. If a person who has lost capacity is in a very frail state, their doctor can decide with their family that it will be in their best interests not to attempt resuscitation. This might be because the attempt to resuscitate them would probably fail and they would die anyway. This would allow them to die in a more dignified way.

‘Living will’ – this is not created formally by the MCA, but is a written statement about what care a person wishes to receive at the end of their life. They might say they would like to be cared for at home for as long as possible. It is a good idea for people to write down their wishes in order to help whoever has to make a best interests decision in the future. Unlike an ADRT, a statement of wishes must be taken into account but is not legally binding.

**Finding out more**

There are a number of good sources of information about the Mental Capacity Act for all sort of different people. The most comprehensive one, which also includes some online training materials, is the Social Care Institute for Excellence

<http://www.scie.org.uk/publications/mca/>

Others with useful leaflets are:

Alzheimers Society

<https://www.alzheimers.org.uk/site/scripts/download_info.php?downloadID=1164>

National Autistic Society

<http://www.autism.org.uk/about/adult-life/advocacy/mental-capacity-act-2005.aspx>

SCC new guidance including best interest meeting template and notes

<http://extranet.somerset.gov.uk/adults-and-health/policies-and-processes/health/>

<http://extranet.somerset.gov.uk/adults-and-health/templates/mental-capacity-and-dols/>

Chris Hamilton, MCA and DoLS Manager. April 2016