NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Equality Impact Assessment Tool MCA

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With **all of us** in mind.

The Mental Capacity Act, 2005

Policy and guidance for service users, carers and practitioners

This policy and guidance should be read in conjunction with the Mental Capacity Act, 2005, and its related Codes of Practice; and the "Making decisions" series of booklets provided by the Department for Constitutional Affairs, the Department of Health and the Public Guardianship Office.

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1.0 Introduction

South West Yorkshire Partnership NHS Foundation Trust is a large and complex organisation which serves over 1 million people and links to Clinical Commissioning Groups and local authorities who also commission our services.

This policy and guidance has been developed to assist staff within the Trust with regard to the complex areas of consent, decision making and forward care planning. This policy specifically relates to powers and duties under the Mental Capacity Act 2005 and Deprivation of Liberty safeguards.

All staff providing care and treatment to service users under our mental health and learning disability services care must be familiar with the scope of the Mental Health Act provisions and those of the Mental Capacity Act when considering the patient's capacity to consent to treatment.

In addition, this policy refers to policy and guidance related to vulnerable adults, lone working and management of violence and aggression. It is therefore important that all staff familiarise themselves with the content of this document.

2.0 Purpose and Scope of the Policy and Guidance

2.1 The underlying philosophy of the Mental Capacity Act 2005 (referred to hereafter as "the Act") is to support individuals in making decisions for themselves and to ensure that an individual who lacks capacity is the focus of any decisions being made, or actions taken on his behalf. It prioritises the interests of the person who lacks capacity, not the views or convenience of those caring for and supporting that person.

2.2 The majority of the Act applies to young people aged 16 and 17, with the entire Act applying to everyone over the age of 18 living in England and Wales. It provides:

- A statutory framework for the assessment of capacity for most purpose and for making decisions on behalf of people who lack capacity.
- For those aged 18 and over, a means, enshrined in law, to make some decisions about their lives in advance, and that these decisions will be binding in the event of the person becoming mentally incapacitated, and therefore unable to make informed

decisions at that time. Logically ,these decisions are now referred to in the Act as advance decisions.

 For those aged 18 and over, a means to appoint someone else to make decisions relating to property and affairs and/or health and welfare decisions.

2.3 The inability to make a decision can be caused by a range of problems, such as; a mental health problem, dementia, learning disability, and physical problems such as toxic confusion, a stroke, brain injury or the effects of drugs or alcohol. This loss can be of a temporary or fluctuating nature or a permanent loss.

2.4 The assessment of mental capacity and making decisions on behalf of others is a complex process. Those who are involved in assessments of capacity and acting on behalf of others have a duty to ensure their practice is evidence based and in keeping with available guidance. Knowledge of this guidance alone will not be sufficient to ensure practice is defensible, and staff will have to be familiar with the contents of the Act, its associated Code of Practice and relevant NICE guidelines.

3.0 Duties

All staff who are providing care and treatment to services users are responsible for ensuring that the provisions of the Mental Capacity Act 2005, its related codes of practice and available guidance is followed in accordance with this guidance. Where this is not followed, reasons are recorded to reflect the deviation from the policy and guidance. The lead Directors for this policy are the Medical Director and Director of Nursing and Quality The development of the policy and its updates is supported by the Trust Legal Services department. Approval of this policy will be sought from the Executive Management Team.

4.0 South West Yorkshire Partnership NHS Foundation Trust's commitment toward people who lack capacity to make decisions

South West Yorkshire Partnership NHS Foundation Trust (hereafter referred to as "the Trust") is committed to enabling service users to access services and to ensure that those individuals who lack capacity to make decisions are provided with high quality care from a knowledgeable and competent workforce. This policy and guidance, alongside the implementation of the related Code of Practice, and Department of

Health guidance, aims to ensure that staff are aware of the requirements of the Act and are able to use the legislation to ensure the protection of people who lack capacity to make decisions.

5.0 The Mental Capacity Act; key points

5.1 The Act applies in England and Wales to people aged16 and over but some parts of the Act, notably Advance Decisions to refuse treatment and Lasting Powers of Attorney are limited to those persons aged 18 or over.

5.2 It is based on what at the time was considered to be best practice and largely codifies what was common law in “advanced directives” and “living wills”. It clarifies what is meant by lack of capacity and ensures that any decision or action taken on a person’s behalf is in that person’s best interests.

5.3 A summary of the key points of the Act is as follows.

- An assessment of capacity must always start with the assumption that a person has the capacity to make his own decisions.

- Once it is confirmed that the person lacks capacity to make the decision the act done for, to or on behalf of the person must be clearly determined to be in their best interests and clearly recorded

- The Act sets out a two stage test for assessing a person’s capacity to make a decision.

- The Act provides a checklist for determining what is in the best interests of a person Greater weight is to be given to the values, wishes, beliefs and preferences when making the best interests decision

- The Act provides ways for a person to plan ahead for a time in the future when they may lack capacity to make a range of decisions

- Clarification of the actions people can take if someone lacks capacity, and provides legal protection from civil or criminal action if the Act has been followed

- It places a statutory duty on those working with a person who lacks capacity to consult other people involved with the person, not just “next of kin” or family members

The Act sets out details for the Independent Mental Capacity Advocate (IMCA), which is the statutory advocacy service for people who lack capacity. In certain circumstances an IMCA **must** be instructed by staff working with the person and their findings **must** be taken into account when making the decision

The Act Sets out the **criminal** offences of "Wilful neglect or ill treatment of a person who lacks capacity".

Provides safeguards concerning research involving people who lack capacity.

Is supported by the public bodies of the Court of Protection, and the Office of the Public Guardian.

Provides for statutory guidance in the form of a Code of Practice that healthcare practitioners, and others, have a "duty to have regard to".

6.0 Decisions to which the Mental Capacity Act does not apply

Please see chapter 1 of the Code of Practice

Nothing in the Act permits a decision to be made on someone else's behalf on any of the following matters:

- Consenting to a decree of divorce on the basis of two years' separation
- Consenting to the dissolution of a civil partnership
- Consenting to marriage or civil partnerships
- Consenting to sexual relationships
- Consenting to a child being placed for adoption or the making of an adoption order
- Discharging parental responsibility for a child in matters not relating to the child's property, or
- Giving consent under the Human Fertilisation and Embryology Act 1990.**Voting**

Where a person is subject to the MHA the requirements of Part 4 or Part 4A (as applicable) must be followed for treatment of mental disorder nothing in the Act is to be taken to affect the law relating to murder, manslaughter or assisting suicide

7.0 Guiding principles

Please see chapter 2 of the Code of Practice

The Act has five key principles which have statutory force. Decisions and actions carried out under the Act should be tested against the principles. These principles provide protection for the person who may lack capacity and those acting on behalf of a person who lacks capacity.

Principle one

A person must be assumed to have capacity unless it is established that he lacks capacity.

Principle two

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.

Principle three

A person is not to be treated as unable to make a decision merely because he makes an unwise decision.

Principle four

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.

Principle five

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.

8.0 Helping people make decisions

Please see chapter 3 of the Code of Practice

8.1 As stated above, the Trust is committed to helping service users make their own decisions, even when circumstances make this difficult. Practitioners must always start from the assumption that a service user has capacity. Providing help with decision making should form part of the care planning processes for people receiving health or social care services.

8.2 Consideration needs to be given to the means of support to help the service user make a decision. The following list is not exhaustive and appropriate support must be developed to meet individual needs:

- Relevant information should be provided in language the person can access and understand.
- Use of signing, translation, or Makaton should be considered
- It may be more useful to communicate in the person's first language
- Does the person communicate using non-verbal means? This form of communication is equally valid and help should be sought to understand it.
- The person may find it easier to make a decision in a different place (for example at home instead of in a clinic)
- Is advice from a specialist required to help the person make the decision (e.g. a doctor, speech and language therapist, financial or legal advisor)?
- Can relatives, friends or carers help? They may have important advice on how the person communicates, or may be able to communicate better with the person
- Use of technology may help, such as videos, DVDs, photographs etc. to help reiterate points.
- Some people may find it easier to communicate at certain times of the day.
- Is medication affecting the person's ability to communicate?
- Avoid unnecessary time limits.

9.0 Assessing capacity

Please see chapter 4 of the Code of Practice

Valid consent must be obtained before starting treatment or physical investigation, or providing personal care, for a person. Case law ('common law') has established that touching a patient without valid consent may constitute the civil or criminal offence of battery. Further, if healthcare professionals (or other healthcare staff) fail to obtain proper consent and the patient subsequently suffers harm as a result of treatment, this may be a factor in a claim of negligence against the healthcare professional involved. Consent may be given by a patient who has capacity or a donee of a Lasting Power of Attorney for personal welfare/ Court Appointed Deputy providing that the decision is within the scope of the donee/deputy's authority.

9.1 The assumption that all adults have capacity is central to the Act. Where a person has the capacity to make a particular decision the decision is his and cannot be overturned by anyone else. Where there is doubt that a person has capacity to make a particular decision, there is a need to determine this.

9.2 Where there are grounds to doubt a person's capacity to make a particular decision, assessment of capacity must be in keeping with the Act and its related Code of Practice. Any deviance from the guidance contained in the Code of Practice must be logical, rational, reasonable and defensible. It is important to recognise that a person who lacks capacity can be very articulate and rational in his reasons for making or not making a particular decision. This needs to be considered in relation to the person meeting the test of capacity. For example, a person with a mental disorder may well be able to articulate very well his reasoning behind a particular decision, but his disorder may prevent him from appreciating the consequences of it.

9.2.1 The Act introduces a two stage test at section 2, to assess capacity;

- Does the person have an impairment of the mind or brain?
- Is the impairment or disturbance sufficient to mean that the person is unable to make the decision in question at the time it needs to be made?

9.2.2 The functional test at section 3(1) states that a person is unable to make a decision for himself if he is unable;

a) To understand the information relevant to the decision,

b) To retain that information,

c) To use or weigh that information as part of the process of making the decision, or

d) To communicate his decision (whether by talking, using sign language or any other means..

9.3 A person may lack capacity for any number of reasons. Capacity is not dependent on any condition alone, but to the effects a condition may have on the ability to make decisions. Whilst the severity of a condition may be a factor in assessment, its severity alone is not the determining factor. For example, a person suffering from a schizophrenic illness may be ill to the extent that he needs to be detained in hospital under the Mental Health Act; however, this does not mean that he necessarily lacks mental capacity to make decisions regarding his treatment.

9.4A persons capacity to make a decision must never be based simply on; their age their appearance assumptions about their condition, or any aspect of their behaviour

9.5 The Code of Practice provides a non-exhaustive list of some of the conditions which **may** lead to a lack of capacity to make a particular decision as follows:

o Acquired brain injury

o Stroke

o Toxic confused states

o Learning disability

o Dementia

o The effects of an illness or a treatment, such as pain, distress, confusion, drowsiness, unconsciousness

o The effects of drugs or alcohol

o Mental health problems including:

- Psychoses
- Anxiety

- Phobias
- Depressive illness
- Other mood problems
- Personality disorder

9.6 Mental capacity is **decision and time specific.** A person is considered to

have capacity for each and every decision he makes. The decision to act in a person's best interests because a lack of capacity has been identified is only for the particular decision at the time it needs to be made.

9.7 Loss of capacity may be temporary or open to fluctuation such as in the case of a diurnal variation. The capacity to make decisions may also be effected by alcohol, drugs; over the counter, prescribed and illicit, it may also be affected by the environment.

10.0 Recording assessments of capacity

10.1 There are no statutory or standard forms for the recording of an assessment of capacity in relation to the Act. The Trust has a form which can be used to record assessments of capacity. This can be accessed through the Trust MCA intranet page and at Appendix A The Local Social Services Authorities also developed recording forms for the purposes of documenting assessment of capacity. These forms may be used when those assessing capacity consider that such a form would be useful.

10.2 It is acceptable to record an assessment of a patient's capacity within the medical or electronic patient records. Any such record should state what attempts were made to enable the person to participate in the decision, what information was provided, what the decision was and, if the patient lacks capacity, on what grounds the patient lacks capacity.

10.3 This record should include a statement as to whether the patient is expected to regain capacity if the decision can be deferred until such a time as the patient regains capacity and what, if any, steps or interventions need to be taken to enable the person gain or regain capacity to make the decision

10.4 Assessments of capacity should be supported by a consent care plan held in the patients electronic records. The care plan should include details of where to find the record of the assessment and the date of the assessment.

10.5 If a decision needs to be made at the time then the best interest decision should also be recorded. A copy of the Trust best interest decision form can be found at Appendix B or in the Trust MCA intranet pages

10.6 All best interest decisions should be supported with care plan held in their patients electronic records.

10.7 In most cases assessment of capacity will take place on a regular, more informal level; however, it is important to appreciate that the test for capacity and the principles to be applied in decision making remain the same and practitioners may still be called upon to justify decisions.

10.8 It is suggested that the form may be of benefit to use in the following circumstances when:

- The decision is about serious medical treatment
- The decision concerns long term accommodation changes
- There is a lack of concurrence about whether or not the person lacks or has capacity
- There is an intention to refer to the Independent Mental Capacity Advocate
- There is a need to have a specific record of the assessment and the rationale behind it suggests that such a form would be useful.
- It is requested by the police for the purposes of furthering their enquiries (e.g. s44 Mental Capacity Act charges)

10. When recording the assessment of capacity of a voluntary patient who lacks capacity to consent to the treatment in preparation for ECT, in the first instance Form 4 should be used to record the assessment, thereafter the ECT record of capacity held within the treatment record booklet should be completed. (For further information refer to the ECT protocol.)

10.10 In cases where an external team or service have requested assistance with an assessment of capacity (such as a request from an acute trust in the case of a patient under their care who also has a mental disorder) the records should show the context of the assessment. In such cases Trust staff would be offering an opinion and would not be responsible for the assessment of capacity or any ensuing best interest decision. The clinician providing the treatment or investigation is responsible for ensuring that the person has given valid consent before treatment begins therefore the responsibility for assessment and decision making would remain with the acute trust and their decision maker.

11.0 Duty to consult as far as is practicable and appropriate

(Please see chapter 5 of the Code of Practice)

11.1 The Mental Capacity Act extends the duty to consult other people in relation to considering best interests. The duty to consult is not restricted to consulting with the person's next of kin, therefore it should be checked whether or not the person has set out his views in a document, appointed a person to act on his behalf, or if there are others such as friends or family involved in his care. If practicable and appropriate you must consult with, and take in to account, the views of the following:

- Anyone the person has previously nominated to be consulted (TheNominated Person)
- Lasting Power of Attorney appointed
- Enduring Power of Attorney appointed
- A Deputy appointed by the Court of Protection
- Professionals involved in the care of the person
- Other persons engaged in caring for, or interested in, the person. This could be carers, friends, supporters, a solicitor or other professional person who has involvement with the person.

11.2 Consideration must be given as to the need to consult further. Depending on the nature of the decision and the seriousness of the consequences, the consultative body for decisions, **may** include specialist advisors, such as speech and language

therapists, mental health professionals, specialists in learning disabilities, psychologists etc.

11.3 Reasons why consultation may not be practicable or appropriate may include the following:

- The person lives abroad and has no contact with the service user
- A relative who is estranged
- A family member who refuses to be consulted
- A family member who himself lacks capacity to be involved in the process
- The urgency of the decision, therefore a lack of time
- There is an abusive relationship the person and the individual available to consult with
- The service user is strongly opposed to the other person's involvement

Confidentiality continues to apply and must be considered before and during any consultation with others. (Refer to paragraph 13 below)

11.4 At times consultation will raise the issue of conflicting views between consultees. This may be as a consequence of the emotive nature of the decision to be made or values and beliefs. Staff should be supportive to the concerns of the family and friends consulted, and where possible offer face to face meetings, mediation or the involvement of an advocate. Ultimately consultees if unhappy with actions taken by trust staff should be provided with details of the Trust complaints procedure.

11.5 Whist staff should consult with those who best know the patient who lacks capacity before making best interest decisions in respect of care and treatment it should be remembered that unless the person has an advance decision or there is a Donee or Court Appointed Deputy with the authority to make the decision in question, the best interest decision rests with the lead clinician (the decision maker).

11.6 Staff should also be aware of the potential of abusive relationships and in such cases should invoke the Safeguarding Adults policies.

11.7 At times the opinions of the patient's family and friends will conflict with valid and applicable advance decisions made by the patient. In such cases unless the

Consultees raise information that would call into question the validity or applicability of the advance decision the care team must follow the patients advance refusal of treatment as set out in the advance decision. Staff should be supportive to the concerns of the family and friends consulted, and where possible offer face to face meetings, mediation or the involvement of an advocate. Consultees if unhappy with actions taken by trust staff should be provided with details of the Trust complaints procedure. Advice is available in such instances from Legal Services (swy-tr.legalservices@nhs.net)

11.8 In cases where no resolution can be found to such a dispute in respect of an advance decision and there is a need to proceed with a treatment the Trust will take the case to the Court of Protect for a decision. In such instances Legal Services will co-ordinate legal proceedings.

11.9 All instances of disputes and disagreements in respect of best interest decisions including those from within the care team, must be recorded in the patient's medical notes and electronic patient records; how the dispute was resolved, what best interest decision was made and by whom

12.0 Best interests

Please see chapter 5 of the Code of Practice

12.1 It is important to remember that where a person lacks capacity to make a particular decision, he can neither consent to it nor refuse it. Any person acting on behalf of a person who lacks capacity **must** act in that person's best interests. The ability to articulate a decision, consent or refusal is not the single determining factor in determining capacity or best interests. Some conditions may enable a person to be very articulate but he may still lack the ability to make an informed decision and therefore lack capacity.

12.2 It is important to consider the following factors when determining best interests:

- What is the decision about?
- Is there a Nominated Person?
- Is there a Lasting Power of Attorney?
- Is there an Enduring Power of Attorney?

- Who needs to be involved in making the decision?
- Who needs to be consulted?
- Who is the decision maker?
- How should the decision be made?
- What is known about the person's previous wishes, feelings and beliefs?
- What are the person's current wishes feelings and beliefs even though lacking capacity?
- What are the practical implications of making decisions in a person's best interest?
- What are the risks and benefits involved?

12.3 There are no statutory or standard forms for the recording of a best interest decision. A copy of the Trust form can be found at Appendix B and on the Trust MCA intranet page. There is no requirement that these forms be used but staff may find it useful in working systematically through the best practice checklist and recording their rational for future reference.

12.4 In instances where staff are managing or assisting with the management of a person who has self-harmed, where the person is able to communicate, an assessment of their mental capacity should be made as a matter of urgency. If the person is judged not to have capacity, then they may be treated on the basis of temporary incapacity (see chapter 2,paragraph 12). Consideration for the use of the MHA 1983 should also be given in such circumstances, and may be applied to compel treatment for the direct consequence of an act of self-harm which is a manifestation of the mental disorder

12.5 Similarly, patients who have attempted suicide and are unconscious should be given emergency treatment .

12.6 However, patients with capacity **do** have the right to refuse life-sustaining treatment (other than for treatment of mental disorder under the Mental Health Act 1983) – both at the time it is offered and for a time in the future. Making a decision which, if followed, may result in death does not necessarily mean that a person is or

feels suicidal. Nor does it necessarily mean that the person lacks the capacity to make the decision now or in advance. If the person is clearly suicidal, this may raise questions about their capacity to make the decision. Further s.62 of the MCA is clear that others cannot be directed to assist a person in their attempt to commit suicide. If a patient with capacity has harmed themselves, a prompt psychosocial assessment of their needs should be offered. However, if the person refuses treatment and use of the Mental Health Act 1983 is not appropriate, then their refusal must be respected. Similarly, if practitioners have good reason to believe that a patient genuinely intended to end their life and had capacity when they took that decision, and are satisfied that the Mental Health Act is not applicable, then treatment should not be forced upon the person, although clearly attempts should be made to encourage them to accept help. The Trust form for the recording of an advance decision to refuse life sustaining treatment is contained within the Trust advance decision form and can be found at Appendix C And on the Trust MCA intranet page

13.0 Record keeping

Please see chapter 4 of the Code of Practice paragraph 4.61

13.1 All those involved in the care and treatment of a person who may lack capacity should keep a record of long term or significant decisions made about capacity. The record should be made in the place where details about a service use are regularly made, such as the electronic patient records or the medical notes. The record should show:

- The decision
- Why the decision was made
- How the decision was made
- Who was involved
- What information was used including how you considered the persons views, wishes and beliefs

13.2 Recording decisions in this way will help staff to demonstrate why they had a reasonable belief in the person’s lack of capacity and that they were acting in the person’s best interests.

13.3 Where a person is judged to lack capacity to consent to day-to-day care, elaborate record keeping is not required. However, if a member of staff's decision is challenged, the practitioner must be able to describe why he had a reasonable belief of lack of capacity and about what was in the person's best interests. The decision about lack of capacity and best interests should always be recorded in the person's case notes. Although this does not need to be done on a daily basis, the record should accurately reflect the decisions and note that it will be reviewed regularly or until capacity is regained.

13.4 It is important to note that where a service user lacks capacity to make a particular decision, e.g. for treatment, or sharing information, then he cannot sign a consent form or any other document relating to consent or refusal. In these cases, those acting on his behalf must act in the person's best interests and records should reflect this.

14.0 Care Planning

Please see chapter 6 of the Code of Practice paragraph 6.34

14.1 Assessment of capacity and judgement of best interests is decision and time specific, it is not possible to write anticipatory care plans which state whether or not a person has capacity and what is in his best interests. Care plans need to indicate what issues should be considered in assessing capacity and what should be considered when judging best interests. Where a care plan is used, entries in the notes relating to the implementation of the care plan must demonstrate the implementation of the Mental Capacity Act.

14.2 It is however possible to describe an approach to assessing capacity and considering best interests, which will assist in recording when such assessments and decisions are made.

14.3 Consideration should be given to writing Advance Care Plans when the person has the mental capacity to participate in the process.

14.4 Advance Care Planning is described as a process of discussion between an individual and their care providers irrespective of discipline or agency. If the individual wishes, their family and friends may be included. This should be conducted with regard to the CPA policy. An Advance Care Plan might include:

- The individual's concerns
- His important values or personal goals for care
- His understanding about his illness and prognosis
- His preferences for types of care and treatment that may be beneficial in the future and the availability of these.

14.5 Advance care planning normally takes place in the context of an anticipated deterioration in the individual's condition in the future, which may lead to a loss of capacity to make decisions. The patient should be offered the opportunity and assistance to make an advance decision and supporting advance statements of wishes. The Trust forms for both the advance decision and the advance statement are available at Appendix C& D And through the Trust MCA intranet pages The person may also wish to forward plan by Making a Lasting Power of Attorney. Trust staff should support service users to access independent legal advice to ensure that the LPA will be able to address the forward plans as the person wishes. Care should be taken to ensure the patient understands the extent of the authority of these documents and in which circumstances they can be over ruled.

15.0 Confidentiality and data protection

Please see chapter 16 of the Code of Practice

15.1 This part of the policy should be read in conjunction with the Data Protection Policy. This policy does not replace the guidance of the Information Commissioner's Office on the Data Protection Act 1998. Where there is doubt advice should be sought from the Trust Information Governance lead.

15.2 Service users have a right to confidentiality. Information can be shared about an individual where the service user has capacity and consents to the sharing of information, where there is a legal duty to do so, or where there is an overriding public interest.

15.3 Where a person lacks capacity to make a decision regarding sharing of information, the following guidance applies (alongside the guidance contained in the Data Protection Policy)

・ Information can be shared if it is in the best interest of the person who lacks capacity to do so. This should be limited to the information which is needed to meet the person’s best interests.

・ Independent Mental Capacity Advocates have a right to access relevant health and social care records.

・ A person may have previously given consent (whilst he had the capacity to do so) for a person or persons to access information, such as a Lasting Power of Attorney or Enduring Power of Attorney. In such cases those disclosing information should be clear about the extent of the Powers.

・ A Deputy appointed by the Court of Protection may have the right to relevant information

・ A person may have previously let his wishes and feelings be known about sharing information, and these must be considered when considering sharing information for a person who lacks capacity. If there is any doubt about sharing information, advice should be sought.

16.0 Mental capacity and risk management

16.1 It is a fundamental principle that people live with elements of risk in their personal lives. When considering what action is in the best interests of a person assessed as lacking capacity to make a decision, there is a need to take into account a balance of that person’s risks and needs.

16.2 It is important when assessing capacity as part of the assessment, that a person is able to understand the risks and consequences associated with making that decision or indeed, of not making a decision. Understanding and accepting risks is an important part of decision making. If the person is unable to understand the risks of a decision, it is more likely than not that he lacks capacity.

16.3 When considering risk taking behaviour, assessors must deliberate whether the person fully understands the consequences of a proposed decision. This includes the person understanding and believing information provided and any negative consequences of the proposed decision.

16.4 Where a person's risk taking behaviour may lead to risk to other people, public protection must be considered. If the behaviour is likely to put the child at risk of harm children and young people under the age of 18 reference should be made to the Trusts Safeguarding and Promoting the Welfare of Children Policy

16.5 It is equally important that those who lack capacity to make decisions are protected from risks as a result of their lacking capacity. This may mean that sometimes actions are taken, against the person's apparent (although non-capacitious) wishes

16.6 There may be occasions when staff themselves face risks associated with assessing capacity and determining best interests. It may be that there are family disagreements or disputes or carers feel strongly about the decisions to be made or disagree with the decisions taken by professionals. These risks must be taken seriously and staff and their managers should address such risks. Where required reference should be made to the Trust Lone Worker Policy and to the Violence and Aggression at Work Policy

17.0 Protection of vulnerable adults

17.1 This part of the Policy should be read in conjunction with the Safeguarding Adults Police.

17.2 People who lack capacity are amongst the most vulnerable people in our community. It is important to recognise that where a person's ability to make some decisions is impaired, the decisions he is able to make, become more important.

17.3 Mental capacity will often need to be considered in cases where adult abuse is suspected or proven. A person with capacity will be able to make a decision about his future care and support, even if this means that he wishes to remain within an abusive environment. However if a person in an abusive situation lacks capacity, then those involved will need to make decision on his behalf based on that person's best interests. This may mean a complex set of circumstances will need to be considered, up to and including the effects of the person remaining within the abusive environment and the effects of removing him from the environment. The wider social aspects of a person's circumstances must be considered when determining what is in his best interests

17.4 Section 44 of the Mental Capacity Act relates to wilful neglect or ill treatment of a person who lacks capacity, and makes these criminal offences (see paragraph 26 below, wilful neglect or ill treatment of a person who lacks capacity). These offences may need to be considered in cases of adult protection. (See Trust policy Safeguarding Adults Policies.

18.0 Independent Mental Capacity Advocate

Please see chapter 10 of the Mental Capacity Act

18.1 Local Authorities are responsible for the commissioning of Independent Mental Capacity Advocacy Services (IMCA). The organisation the Trust MCA intranet page is linked to the SCIE website which maintains an up to date data base of IMCA services and their contact details.

18.2 Referral to the IMCA service is restricted to a set of defined circumstances. The IMCA service it is designed to assist the most vulnerable members of society who not only lack capacity, but who also have no friends, carers or supporters, or those who may be involved in adult protection cases.

18.3 The IMCA service is for people who lack capacity and who do not have friends, carers or supporters and there needs to a decision taken about serious medical treatment **or** consideration is being given to moving the person into long term accommodation (defined as more than 28 day in hospital or 8 weeks in a care home). In these defined sets of circumstances, staff a have legal **duty** to instruct the IMCA.

18.4 The IMCA **may** be instructed in cases where a care review is to consider movement from one care home to another, providing the person concerned lacks capacity to make the decision and there is no one other than a paid carer for the current care team to consult with.

18.5 The IMCA **may** also be instructed where the person who lacks capacity is the subject of adult protection procedures, whether or not the person is without friends or relatives for the care team to consult with. This referral should be considered where it is thought to be of some benefit to the case.

18.6 Guidance on who to refer, how to refer and to which service are included within the Trust MCA Intra-net pages

19.0 Planning ahead for the future

Please see chapter 7 of the Code of Practice

19.1 A person can plan ahead for a time when he may lack capacity. The Mental Capacity Act provides three ways of doing this.

19.2 This is a particularly complex area and staff involved in implementing this part of the Act are advised to consider carefully the guidance contained within the MCA Code of Practice and Chapter 9 of the MHA Code of Practice; Wishes expressed in advance.

19.3 Ways to plan ahead can be through:

- Lasting Powers of Attorney
- Advance decisions to refuse treatment
- Statement/s of wishes, feelings and beliefs

20.0 Lasting Power of Attorney

Please see chapter 7 of the Code of Practice

20.1 The Mental Capacity Act provides ways in which a person can plan ahead in case he loses capacity in the future. Lasting Powers of Attorney replace and expand the system of Enduring Powers of Attorney. From October 2007, only Lasting Powers of Attorney can be created. If however, a person has already made an Enduring Power of Attorney and it has not been registered, it can still be registered after 2007 and will basically take effect as a Property and Affairs Lasting Power of Attorney. The effect of this is that for many years both systems will be in place.

20.2 There are two types of Lasting Power of Attorney (LPA):

- Property and affairs LPA
- Personal Welfare LPA

20.3 The property and affairs LPA is similar to an EPA. It only relates to financial matters and can be used when the person still has capacity if that power is given to the attorney

20.4 The personal welfare LPA can only be used when the person who created it lacks capacity and ceases to have effect once the person regains capacity to make their own health and welfare decisions.

20.5 LPA can only be made when the person making it is aged 18 or over, has the capacity to understand the importance of the document, and the power they are giving to another person. The person to whom the Power has been given is known in the Act as the "donee" but is also known as an Attorney. Attorney is the term used in the Code of Practice. There can be more than one attorney appointed and they may be allowed to act independently or only together.

20.6 The personal welfare LPA, means that for the first time a person can nominate another person to make decisions on his behalf in relation to both health, and personal welfare

20.7 It is essential to read the LPA, to understand the extent of the Attorney's power and any restrictions or limitations placed on his decision making authority.

20.8 Before an LPA can be used it must be registered with the Office of the Public Guardian (see paragraph 29 below, The Office of the Public Guardian). Without registration an LPA cannot be used. An Attorney should be able to produce the relevant documentation from the Office of the Public Guardian. It will have an official seal stamped on every page.

20.9 If there is doubt about the validity of an LPA the Trust Legal Services should be contacted, who will provide support and advice including where necessary contacting the Office of the Public Guardian on behalf of the Trust

20.10 If the person who lacks capacity has created a personal welfare LPA, the Attorney is the decision maker on all specified matters relating to the person's care and treatment. Unless the LPA specifies limits to the Attorney's authority, the Attorney has the authority to make personal welfare decision and consent to or refuse treatment on the donor's behalf.

20.11 The Attorney must act in the person's best interests and if there is a dispute that cannot be resolved, it may be referred to the Court of Protection

20.12 If the decision is about life sustaining treatment, the Attorney only has the authority to make the decision if the LPA specifies this.

20.13 In cases where a matter is referred to the Court of Protection for a decision, in respect of an LPA the Act provides that life sustaining treatment can always be given while the application is being made

20.14 Enduring Powers of Attorney only relate to property and affairs and do not give the person with the Power of Attorney the right to make health or welfare decisions on behalf of a person without capacity; however the Attorney should be consulted on matters of serious medical treatment.

20.15 Enduring Power of Attorney (EPA) can be used when the person who has made the EPA still has capacity if permitted by the EPA.

20.16 Employees of the Trust must not agree to be an Attorney for a service user for whom they are providing care, treatment or support. In order to avoid the possibility of members of the patient's family raising issues about the reason for and nature of the involvement of staff, Trust employees should not assist with the wording of an LPA but rather direct or support the patient to seek legal advice. Trust staff may, if satisfied of the person's capacity to make the LPA, sign the capacity certificate contained within the application. A full record of the assessment of capacity should be made within the electronic patient record.

21.0 Advance decisions to refuse treatment

Please see chapter 9 of the Code of Practice

21.1 Previously commonly known as living wills, or advance directives, these documents existed prior to the enactment of the Mental Capacity Act. The MCA clarifies the legal status of these decisions, now known as Advance Decisions, Advance Statements and Advance Decision to refuse Life Sustaining Treatment, and sets out how they should be made. People can, when they have the capacity to make the decision, make an advance decision to refuse specified treatment (but not basic care – see paragraph 19.9 below) under specified circumstances for a time in the future when the treatment may be considered to be an option. The refusal of treatment can extend to include the refusal of life sustaining treatment.

21.2 An advance decision to refuse treatment can only be made by a person aged 18 or over who has mental capacity at the time the advance decision is made. If the advance decision is valid and applicable, then it has legal force. An advance decision may be verbal or in writing whilst an advance decision to refuse life sustaining treatment must be in writing. It must be signed by the maker in the presence of a witness who must also sign it. Trust staff must not act as the independent witness to the advance decision to refuse life sustaining treatment. It can be in any format and a copy should be in the person's medical notes. (see 19.6 below) In both cases the decision must set out the circumstance in which the refusal will apply and the specific treatment that the person is refusing. The Trust form for the recording of advance decisions including those which refuse life sustaining treatment can be found at Appendix C and on the Trust MCA intranet page

21.3 An advance decision to refuse treatment may be given by the person verbally to a member of staff. In such instances the member of staff should record the decision and any witness to the verbal advance decision. The care team must review this decision in detail with the person to ensure the exact intention of the decision is understood by all concerned.

21.4 Advance decisions can avoid the need for clinicians to make difficult decisions and for them to be sure they are acting in accordance with what the service user wanted. They offer the additional benefit of facilitating participation and joint care planning for a time in the future when the person may lack the capacity to engage in discussion and make decisions in respect of treatment.

21.5 Staff should not act as a witness to an advance decision. Service users should be encouraged to discuss any advance decisions with family, friends or external carers, to ensure that they are interpreted as the service user intended and to avoid family dispute in the future.

21.6 Advance decisions to refuse life sustaining treatment must be verified by a specific statement that says the advance decision is to apply to the specified treatment even if the withholding of that treatment puts the person's life at risk. This statement must also be in writing, signed by the maker and the signature must be witnessed. If a person has already made an advance decision to refuse treatment, he should be

advised and encouraged to review it in light of the requirements of the Mental Capacity Act.

21.7 If Trust staff are in a position to action an advance decision to refuse treatment, they must consider if the refusal is both valid and applicable in the current circumstances. In considering the validity of an advance decision, staff should have regard to the following:

- Has the advance decision been withdrawn in the period between making it and the need to action it?
- Has it been overridden by the making of a Lasting Power of Attorney?
- Has the person acted in a way which is inconsistent with the advance decision, e.g. by making comments about his future?
- If it is about life sustaining treatment, is it signed, witnessed and contains or is accompanied by a statement recognising that it applies to life sustaining treatment?

21.8 In considering the applicability of the advance decision, practitioners should have regard to the following:

- Does the advance decision specify the treatment which is being refused, whether in lay or medical terms?
- Does the advance decision to refuse treatment specify any circumstances which will apply, and are those circumstances currently present?
- Are there any reasonable grounds for believing that there have been changes in circumstances which would have affected the person's advance decision (e.g. advances in medical treatment)?

21.9 A person cannot make an advance decision to refuse basic or essential care, such as warmth, cleanliness, offer of oral food and fluid. Note that artificial nutrition, such as feeding via a naso-gastric tube and fluid is treatment and can be refused.

21.10 A person cannot make an advance decision to demand a specific medical treatment, he can only refuse treatment. If a person has made a statement, indicating

that he has preferred treatments, these should be given due consideration when determining his best interests.

21.11 A person cannot make advance decisions which demand his life to be ended.

21.12 An advance decision that does not fulfil the requirements to be valid and applicable is not binding but should still be taken as an advance statement when considering any best interest decision – see the next section.

21.13 In cases where a matter is referred to the Court of Protection for a decision in relation to the validity or applicability of an advance decisions the Act provides that life sustaining treatment can always be given while the application is being made.

21.14 Advance decisions to refuse treatment for a mental disorder can be overruled by Part 4 of the MHA but a record of the reason why the advance decision has been set aside must be made and the reasons explained to the person when they have regained capacity to make their treatment decisions.

21.14 When a person under the care of the Trust has been given a diagnosis of a life limiting illness Trust staff should advise the patient of the option for creating advance decisions.

22.0 Statements of wishes, feelings and beliefs

22.1 These are a formal way for an individual to make known his personal desires in respect of his care and treatment. They assist family, friends ,and professionals determine best interests, should that person lose capacity. It must be borne in mind that these are not legally binding. An individual cannot demand that they are met. They can include anything that is important to the person e.g. the need for a vegetarian diet, religious practices, or the wish to have a pet looked after, or moved with the person into residential care. They can also indicate the type of treatment a person would like to have for a particular disorder, including specific drugs or other treatments that have been successful for the person in the past.

22.2 Advance statements can work in conjunction with advance decisions, with a decision stating what treatment the person refuses and the statement providing guidance for previously effective treatment or preferred routes of administration of medication.

22.2 Those making best interest decisions on a person's behalf have a legal duty to have regard to such a statement in considering that person's best interests. Not complying with the statement must be for reasonable and rational reasons related to the final decision of the best interests of the person and recorded in the electronic patient record.

22.3 Statements of wishes, feelings and beliefs need not be in writing, but those that are written down and given to family, friends and health and social care professionals are more likely to be known about and followed.

22.4 Where staff are involved with a person who wishes to plan for the future, they should give advice, support and assistance if the person wishes to make such a statement. The Trust form to record an advance statement can be found at Appendix D or through the Trust MCA intranet page

23.0 Restraint

Please see chapter 6 of the Code of Practice. This section should be read in conjunction with paragraph 25 below; Interface with the Mental Health Act

23.1 Section 6 of the Mental Capacity Act defines restraint as the use or threat of force when an incapacitated person resists, and any restriction of liberty or movement whether or not the person resists. Restraint is only permitted if the person using it reasonably believes it is necessary to prevent harm to the person lacking capacity, and that any restrain used is **proportionate** to the **likelihood** and **seriousness** of the harm. If restraint is used in this way and recorded, then those undertaking it are protected by the Mental Capacity Act.

23.2 The Mental Capacity Act (section 6(5)) makes it clear that the Act does not provide protection for an action which deprives a person of his liberty within the meaning or the Human Rights Act. Any action which deprives a person of his liberty without using legislation will be reported under the Safeguarding Adult Procedures.

24.0 Research

Please see chapter 11 of the Code of Practice

24.1 The Mental Capacity Act sets out parameters for research which may be lawfully carried out if an "appropriate body" (normally a Research Ethics Committee) agrees it is safe, related to the person's condition and produces a benefit to the person that

outweighs risk/burden. The Trust is part of West Yorkshire Mental Health Research Consortium and its research governance is fully compliant with the Act.

24.2 Carers or nominated third parties of an incapacitated person must be consulted and agree. If the person shows any signs of resistance or indicates in any way he does not want to take part, he must be withdrawn from the research.

25.0 Interface with the Mental Health Act

Please see chapter 13 of the Mental Health Act Code of Practice 25.1 The Mental Capacity Act can be used to treat a person for mental disorder when he cannot consent because he lacks capacity, and where the treatment is in his best interest and is not being used to compel treatment.

25.2 The Mental Capacity Act cannot be used to detain a person in hospital. Where a person needs to be detained because he is suffering from a mental disorder, then he is assessed with a view to detention under the Mental Health Act.

25.3 If a person is detained under the Mental Health Act, the Mental Capacity Act becomes subordinate legislation and therefore treatment can be given for mental disorder without the patient’s consent in accordance with Part 4of the MHA.

25.4 The MHA Code of Practice states (9.9) even where clinicians may lawfully treat a patient compulsorily under the Mental Health Act, they should where practicable, try to comply with the patient’s wishes as expressed in an advance decision.

25.5 The Mental Health Act Code of Practice requires(25.56) that consultees inform the SOAD of any past and present views and wishes of the patient and that the SOAD should give due weight to them when making their decision to authorise treatment.

25.6 The Mental Health Act 1983 as Amended by the Mental Health Act 2007 recognises the authority of an advanced decision to refuse ECT under s58A (See the Trust ECT protocol); however the powers contained within s62 MHA may override the advance decision to refuse ECT should this become life sustaining treatment.

25.7 The Mental Health Act 1983 as Amended by the Mental Health Act 2007 recognises the authority of the advance decision and LPA (health and welfare) in respect of treatment for community (CTO) patients

25.8 Where a person who is subject to the Mental Health Act is moved to another hospital or care home under the provisions of the Mental Health Act, there is no requirement to consult an Independent Mental Capacity Advocate

25.9 For most other purposes, the Mental Capacity Act will still apply to those detained under the Mental Health Act, for example for the treatment of physical disorders.

26.0 Children and Young People aged 16 – 18

Please see chapter 12 of the Code of Practice.

26.1 There is an overlap between the Mental Capacity Act and the Children Act for 16 and 17 years, and most of the provisions of the Mental Capacity Act apply. Decisions made on behalf of young people aged 16 and 17 must be in their best interests when they lack capacity and the decision makers should normally consult those with parental responsibility.

26.2 Parts of the Mental Capacity Act do not apply to young people aged 16 and 17. A young person cannot make a Lasting Power of Attorney or an advance decision to refuse treatment. However case law has shown that the closer the young person is to adulthood, the greater the weighting that is given by the Court to the young person's wish or preference. Where young people are approaching transition between children and adult services consideration should be given to supporting the young person to set out their views, wishes and preferences in respect of their care and treatment in order to facilitate a successful transition as outlined in NICE Guidelines

26.3 The Court of Protection has no power to make a will on behalf of a person under 18.

26.4 For those under 16, only two parts of the Mental Capacity Act apply. The Court of Protection can make decisions relating to property and affairs of a person under 16, and the criminal offences of wilful neglect or ill treatment of a person who lacks capacity apply to all age groups.

27.0 Disputes and disagreements

Please see chapter 15 of the Code of Practice

27.1 The Code of Practice makes it clear that any disputes relating to either assessment of capacity or best interest need to be resolved quickly and in a cost effective manner.

27.2 It is likely that there will be challenges in relation to both assessments of capacity and best interest decisions. These issues can be very emotive subjects for those who care for a person who lacks capacity. It is possible that there may be disagreements where the carer(s) have a different opinion from professionals on capacity or best interests, or where families disagree with each other. It is also possible that there will be several opinions as to what action is in a person's best interests, and it may be difficult to get a consensus opinion on the best action to take

27.3 It is important to try to resolve disagreements and disputes at a local level. Good communication and open dialogue are important but it is recognised that issues may not always be resolved at this level.

27.4 Where significant persons are involved in the person's life every effort should be made to consult with, and involve them and arrive at an agreed decision provided this is felt to be in that person's best interests and meets his assessed social and/or medical needs

27.5 A case conference or mediation may be useful. Where agreement cannot be reached assistance is sought from the employee's line manager or senior manager, further meetings may be necessary including formal complaints through the route of the Trust Customer Services or by seeking legal advice.

27.6 If agreement cannot be reached, the family or carers have recourse to the complaints procedures of the agencies involved

27.7 Recourse to the Court of Protection should be the last resort if no agreement can be reached. When seeking a court declaration contact the Director of Nursing and Quality or the Assistant Director Legal Services

28.0 Wilful neglect or ill treatment of a person who lacks capacity

Please see chapter 14 of the Code of Practice.

28.1 Section 44 of the Mental Capacity Act (2005) covers the criminal offences of wilful neglect or ill treatment of a person who lacks capacity. These offences are punishable by a fine or a sentence of up to five years imprisonment or both.

28.2 These offences may apply to anyone caring for a person who lacks capacity – this includes family, carers, health or social care staff in hospital, care homes and those providing care or support in a person's home.

28.3 Ill treatment and neglect are separate offences. For a person to be found guilty of ill treatment, he must either:

- have deliberately ill treated the person, or
- be reckless in the way he was treating the person

28.4 It does not matter whether the behaviour was likely to cause, or actually

caused, harm or damage to the victim's health.

28.5 The meaning of wilful neglect varies depending on the circumstances. But it usually means that a person has deliberately failed to carry out an act he knew he had a duty to do.

28.6 Where ill treatment or wilful neglect is suspected, the police must be informed and the Safeguarding Adults Procedure should be instigated.

29.0 Protection from liability

Please see chapter 6 of the Code of Practice.

29.1 Section 5 of the Mental Capacity Act (2005) allows carers, healthcare and social care staff to carry out certain tasks without fear of liability. These tasks involve the personal care, healthcare or treatment of people who lack capacity to consent to them. This is to ensure that acts can be carried out in a person's best interest where he lacks capacity.

29.2 To ensure protection from liability, it is important that those acting on behalf of others observe the five principles of the Mental Capacity Act and act reasonably in assessing capacity and in determining and carrying out best interest decisions and recording both in the electronic patient record. The decision maker is treated as being

in the same position as if the individual they are acting for had capacity and had consented to the action.

29.3 Those involved in the provision of care, support or treatment of a person who lacks capacity have a legal duty to have regard to the guidance contained within the Code of Practice. Staff should follow the guidance in the Code of Practice unless there are rational and justifiable reasons for not doing so. There are no specific legal sanctions in a failure to comply with the Code but failure to do so will be used in any disciplinary proceedings and can also be used in evidence before a court or tribunal or in any civil proceedings.

29.4 South West Yorkshire Partnership NHS Foundation Trust expects that the practice of its employees will be in keeping with the guidance contained in the Code of Practice, unless there are justifiable reasons for deviating from it. Any deviation from the Code of Practice and the reasons for this must be clearly recorded.

29.5 For these reasons, the Trust expects that that staff who work with people who lack capacity are familiar with the contents of the Code of Practice and are up to date with their mandatory MCA training.

30.0 The Court of Protection

Please see chapter 8 of the Code of Practice.

30.1 The Court of Protection has jurisdiction relating to the whole of the Mental Capacity Act and is the final arbiter for capacity matters. It has its own procedures and nominated judges. In cases where there are particular concerns or an agreement cannot be reached relating to capacity or best interests, the Court of Protection can be consulted to make a judgement.

30.2 This will deal with all serious unresolved matters relating to capacity welfare, finance, serious medical treatment and protection. The Court can make a decision where there is a single issue or appoint a Deputy where there are ongoing issues.

30.3 In cases where a matter is referred to the Court of Protection for a decision, including questions about advance decisions and/or LPAs the Act provides that life sustaining treatment can always be given while the application is being made

30.4 The Court of Protection has the option of issuing a s.49 direction. This court order requires that as part of their NHS duties staff are required to make assessment, provide treatments and reports to the Court to enable the court to make it's decision. In order that the Trust is able to comply with the Court Rules, all approaches for reports for the Court of Protection must be directed to Legal Services who can be contacted at swy-tr.section49@nhs.net.

31.0 The Office of the Public Guardian

Please see chapter 14 of the Code of Practice.

The Public Guardian and his staff are the registering authority of LPAs and deputies. They supervise deputies appointed by the Court of Protection and provide information to the Court to help make decisions. They also work together with other agencies such as the police and social services, to respond to any concerns raised about the way in which an attorney or deputy is operating. A Public Guardian Board scrutinises and reviews the way in which the Public Guardian discharges his duties.

32.0 Deprivation of Liberty

To be read in conjunction with the DoL Safeguards code of practice and Mental Health Act code of practice chapter 13

32.1 The Mental Health Act (1983) as Amended by the Mental Health Act (2007) amends the Mental Capacity Act to incorporate the Deprivation of Liberty (DoL) Safeguards. The Safeguards are intended to protect the interests of those people who have a mental disorder and lack capacity to consent to the arrangements made for their care or treatment, who are deprived of their liberty within the meaning of Article 5 of the European Convention of Human Rights within either a hospital or registered care home setting.

32.2 A deprivation of liberty arises when a person who has a mental disorder and lacks capacity to consent to being in hospital or a care home for the purposes of their care or treatment is being kept in such a setting. Furthermore, he would be prevented from leaving if he were to try and do so and as a consequence of him lacking capacity to consent to the care or treatment that he is receiving, staff can be said to have full and effective control of his care and treatment. This would mean that decisions

regarding his care, treatment and any investigations or assessments are effectively being made under the provision of best interest decisions.

32.3 If a care plan can be reviewed to create a restriction of liberty rather than the proposed DoL then this should be done. Advice is available from the local MHA office or the Trust Legal Services (swy-tr.legalservices@nhs.net). If the care plan needs to be delivered in a such a restrictive way and the person meets the criteria for detention under the MHA then a MHA assessment must be organised in order to provide the person with the opportunity to access the safeguards available under this Act and avoid an unlawful detention.

32.4 There are six criteria which must be met prior to any authorisation being granted by the appropriate Supervisory Body. They are;

1. **Age Assessment**; the person must be over the age of 18 years

2. **No Refusals Assessment**; there are no Advance Decisions refusing the treatment intended to be provided whilst the person is being deprived of his liberty nor any Donee or Deputy who has the authority to refuse such a treatment is doing so.

3. **Mental Capacity Assessment**; the person must lack capacity to consent to being in the place where the proposed care and treatment are to be given.

4. **Mental Health Assessment**; the person has a mental disorder within the meaning of the MHA, but including learning disabilities

5. **Eligibility Assessment**; does the person meet the criteria for an application under the MHA. Note this does not mean that the person must be detained under the MHA, but that he meets the minimum criteria for detention under the MHA.

6. **Best Interest Assessment**; that it is in the person's best interests to be deprived of his liberty in this environment for the purpose of providing care or treatment.

32.5 The above assessments are conducted by a minimum of two assessors who are; the Mental Health Assessor and the Best Interest Assessor. They are appointed by the Supervisory Body and have in the case of an Urgent Authorisation 7 calendar days to complete all six assessments and the reports and the recommendations to the Supervisory Body Panel for authorisation or refusal of the DoL application, or in the case of a Standard Authorisation, 21 calendar days.

32.6 When a care team consider that they may have a DoL and that they are unable to avoid this level of care plan then the doctor in charge of treatment or agreed member of the clinical care team must contact the local MHA/MCA office for the appropriate DoL application form. The form will need to be completed by the team and returned promptly to the MHA office who will submit the form to the appropriate Supervisory Body. Assistance in the decision making and completion of the form is available from Legal Services.

32.7 The appointed assessors will contact the ward and arrange to attend to meet with the person and members of staff to complete their assessments. Staff must provide the assessors with information to assist the assessment process, this includes access to appropriate medical and RiO records and any relevant recent assessments. This does not permit full access to all of the person's records, only those that are relevant to the assessment process.

32.8 The Ward and the MHA Office will be notified of the decision of the Supervisory Body. Once the person is subject to a DoL authorisation he is known as the Relevant Person. This will include the duration of the authorisation (up to 12 months), any conditions which are attached to the authorisation and the name of the Relevant Persons Representative.

32.9 It is the responsibility of the ward staff to give the patient who is now subject to the DoL authorisation;

1. A copy of the authorisation form to the Relevant Person and any IMCA instructed for that person

2. Do everything practicable to explain to the Relevant Person both orally and in writing what the effect of the authorisation is

3. The Relevant Person's right to apply to the Court of Protection for it to be terminated

4. Inform Relevant Persons family, friends and carers about the authorisation so that they can support the Relevant Person this may be done in person, by telephone , e mail or letter

5. Record in electronic patient record the steps taken to involve the Relevant Person's family, friends and carers and anyone else with an interest together with their views and with details of any IMCA who has been instructed

32.10 The ward or unit must keep a record of the involvement of the Relevant Persons Representative including their visits to see the patient (known as the Relevant Person), attendance at ward rounds and their inclusion in the care planning.

32.11 The MHA office will notify the clinical team one month before the DoL authorisation is due to expire. The care team must then determine if a further period of DoL authorisation is required. The MHA office must be notified of the decision to ensure that the appropriate forms are supplied to the care team for completion. These forms must be returned to the MH Office for submission to the relevant Supervisory Body. A detailed Guidance for the Clinical Process is available on the Trust MCA intranet pages along with all forms Further assistance with this process is available from the local MHA Office or Trust Legal Services.(swy-tr.legalservices@nhs.net)

32.12 The authorisation will only have relevance for the ward for which it has been provided. Its authority is non-transferable. In the event that the person needs to be moved, e.g. a transfer to the acute trust or move to another unit the MHA office must be notified immediately and the Supervisory body informed to enable suspension of the authorisation and lawful care plan.

32.13 Those aged 16 and 17 sit outside the scope of the DoLS, however to care and treat a young person in circumstances which may amount to them being deprived of their liberty may require an application to the Court of Protection and Trust Legal Services must be notified as soon as practicable (swy-tr.legalservices@nhs.net)

32.14 Those adults who are being cared for in settings which amount to them being deprived of their liberty but are not in a hospital or registered care home may require authorisation form the Court of Protection. Where such circumstances are suspected the clinical team must contact the Trust Legal Services for advice (swy-tr.legalservices@nhs.net)

33.0 Training and Compliance with this policy

Training is available to staff through the mandatory training programme. Specialist advisors where applicable will and do incorporate within training programmes

elements of the Mental Capacity Act specific to their speciality. Information is available in the form of leaflets for patients, carers and staff and are accessible on the Trust MCA intranet page and the department of constitutional affairs. Compliance with this policy will be monitored through review of incidents and audit within each two year period from approval of this policy. MCA compliance is monitored through the Trust Mental Health Act Committee who will also commission specific and additional audits and reviews as required.

34.0 Duties

34.1 Trust Board is responsible for approving the policy for the approval of this policy.

34.2 The Lead Director is responsible for ensuring that the policy has been developed in line with the trust policy for the development, approval and dissemination of policy and procedural documents.

34.3 General managers, clinical leads and team managers are responsible for ensuring that staff in their area of responsibility are aware of their responsibilities under the policy and that they follow the policy.

34.4 All clinical staff are responsible for ensuring that their actions comply with the policy.

34.5 Mental Health Act Office staff are responsible for advising on the practice related to the policy insofar as it is governed by the Mental Capacity Act 2005.

35.0 Principles

This policy seeks to describe the trust's duties under the Mental Capacity Act, ensuring that all patients are involved in decisions about their care to their maximum ability, or where they lack capacity to be involved in decision making about their care there are legal safeguards in place.

36.0 Equality impact assessment

The policy has had an equality impact assessment, (appendix A).

37.0 Dissemination and implementation arrangements

The policy will be disseminated through the trust information channels and through professional groups. It will be placed on the trust intranet.

38.0 Process for monitoring compliance and effectiveness

Compliance with the MCA, including the completion of capacity assessments where required will be monitored by clinical services on a daily basis. More significant capacity decisions will be monitored by senior clinical staff with advice from the Mental Health Act Office

39.0 Review and revision arrangements

The policy will be reviewed by the Assistant Director, Legal Services on behalf of the accountable director by the review date, or earlier if required. Previous copies will be archived in line with trust procedures.

40.0 References

Department of Constitutional Affairs (2007) Mental Capacity Act 2005: Code of Practice TSO London

Mental Capacity Act 2005

Ministry of Justice (2008) Mental Capacity Act 2005 Deprivation of Liberty Safeguards: Code of Practice to supplement the main Mental Capacity Act 2005 Code of Practice TSO London

41.0 Associated Documents

Department of Health (2015) Mental Health Act 1983: Code of Practice TSO London

Mental Health Act 1983

Safeguarding adults at risk of abuse or neglect policy

Safeguarding and promoting the welfare of children policy

Appendix A

Mental Capacity Assessment Form

Name: **DOB:**

Ward / Team: **Date of Assessment:**

What practicable steps have you taken to enable the person to participate in the assessment? e.g aids to communication, translator, time place and people present, written or pictorial information
Specify anyone who has been consulted to assist in this assessment e.g. someone who knows the person well, a Speech and Language Therapist, a clinical specialist.
Stage1
Does the person have an impairment of, or disturbance in the functioning of, the mind or brain? If 'yes' give specific details, if 'no' then the Mental Capacity Act does not apply.
Details of decision to be made
Stage 2
1. Has the person understood the decision to be made and the consequences? **YES / NO** Give specific details showing your evidence to support your findings.
2. Is the person able to retain the information long enough to make a decision? **YES / NO** Give specific details showing your evidence to support your findings.
3. Has the person understood and weighed up the options before making a decision? **YES / NO** Give specific details showing your evidence to support your findings
4. Has the person communicated his / her decision? **YES / NO** Give specific details of how this was done, including the communication methods used

CONCLUSION

If the answer to any question in stage 2 above is 'no' then the person lacks capacity to make decision.

Does the person have capacity to make the decision? Please tick appropriate box		
Yes		The person makes their own decision even if it is an unwise one
No		Proceed to the best interest decision making process

Signature of person completing the assessment: …………………………………………

Date: ………………………Name / Designation of person completing form……………

Appendix B

Best Interest Decision Form

Name: **DOB:** **Ward / Team:**

1. What decision has to be made?
2. Mental Capacity Assessment **relating to this decision** was completed as follows
Date: By Who? Where is the assessment recorded?

A best interest decision can only be made if the person is proven to lack the capacity to make the decision for him / herself.

Only continue with this form if a Mental Capacity Assessment has been completed and the person is shown to lack capacity to make this decision for him / herself.

3. Has an IMCA been instructed **YES/NO** **If yes** please provide IMCA details; name, contact details & where a copy of the IMCA report is held
4. Is there any advance care plan in place that would have the lawful authority to make this decision e.g. Advance decision, Lasting Power of Attorney, Court Appointed Deputy or Court Order **YES / NO** **If yes** please provide details of the authority and where the copy is held
5. Is there any advance statement or evidence of the person's views, wishes, preferences or beliefs relating to the decision to be made? **YES / NO** **If yes** give details below including where the information is recorded or who has provided the information.
6. Does the decision have to be made now, or could it be postponed? **YES / NO** **If yes** please detail any steps to be taken whilst being postponed to enable the person to make the decision
7. List all those involved in the 'best interest' decision making, giving name and designation and identify the decision maker

8. What steps have been taken to enable the person to participate in the decision making **e.g.** how was the person supported to attend the meeting, to participate in the decision making
9. What steps have been taken to enable the person's family and friends to participate in the decision making **e.g** explanations provided in accessible language, invited to attend, views sought if unable to attend
10. List **all** the possible options that are available in relation to this decision

11. List the potential benefits of option 1	List the potential risks of option 1
12. List the potential benefits of option 2	List the potential risks of option 2
13. List the potential benefits of option 3	List the potential risks of option

14. Summarise the key points discussed, and detail any differences of opinion
15. Outline the final decision made, and give the reasons for this

Name of person completing the form		**Date:**
Signature		
Designation		

BID Form V2 March 2018
Legal Services

Appendix C

Advance Statement

This is my advance decision to be followed in case I am unable to participate in decisions about my treatment because of a lack of mental capacity.

Name:	
Address:	
Date of Birth:	
Distinguishing marks:	
Name of clinician with whom this was discussed:	
Designation of clinician with whom this was discussed:	
Date:	
Clinicians contact Address:	
Clinicians contact Tel No:	
GP:	
GP contact details:	
Other professionals consulted and purpose	

Name of; family members, friends, advocates, professional or others as identified who know, and understand about this advance decision.

In case of dispute or the need to make a best interests decision, I would like to have those individuals marked with an * to be consulted. He/she has given permission to be contacted and consulted as to their knowledge of my wishes, beliefs, preferences and values.

Contact Name	Contact Address	Contact Tel Number	Does the contact have a copy of the advance decision?

If the advance decision is intended to apply even if your life is at risk, that is it is intended to refuse life sustaining treatment then this form **must** be signed and independently witnessed to confirm that you make the decision of your own free will and not as a consequence of pressure from others. Forms without the person's signature and the signature of an independent witness will be invalid in these circumstances. It is Trust position that Trust staff should not act as the witness.

You should note that in certain circumstances decisions regarding refusal of treatment for mental disorder may be overruled if you are subject to detention in hospital under a section of the Mental Health Act 1983.

Your advance decision can only refuse treatment. It cannot refuse basic care. Your advance decision cannot demand particular treatment or provide consent to a treatment option for a time in the future when you are unable to give consent.

Appendix C

Details of my advance decision/s

In the event that I lack mental capacity to make decisions about my health care and treatment I have made the following decisions to refuse treatment. I understand that if I am subject to detention in hospital under the Mental Health Act 1983 decisions regarding the refusal of medication for the treatment of my mental disorder may be over ruled. I understand that in certain circumstances decisions to refuse other health care treatment may be over ruled by the MCA 2005 whilst a decision is sought from the appropriate Court

Advance decision/s

Specific treatment/s which I do not wish to receive	The specific circumstances under which I wish to refuse the treatments

I understand that I cannot refuse basic care

I confirm that I am 18 years of age or older and understand that this document remains effective until I make it clear my wishes have changed. (The wishes of people under 18 years will be taken into consideration but are not legally binding)

Completed by the person making the advance decision	
Signed:	
Name:	
Date:	

Appendix C

<table>
<tr><th colspan="2">To be completed by the clinician providing support and assistance</th></tr>
<tr><td colspan="2">I confirm that the person named above has capacity to make the decisions recorded above.</td></tr>
<tr><td colspan="2">The assessment of capacity to make the decision(s) above is/are recorded in;
• RiO/SystemOne progress records dated………………………………………
• RiO/SystemOne consent to treatment care plan………………………………..
• Paper copy medical notes under section………………………………………
• Other………………………………………………………………………….</td></tr>
<tr><td>Name:</td><td></td></tr>
<tr><td>Designation:</td><td></td></tr>
<tr><td>Date:</td><td></td></tr>
</table>

Appendix C

Advance decision/s to refuse life sustaining treatment/s

Specific treatment/s which I do not wish to receive even if the refusal of treatment/s may risk my life or result in my death	The specific circumstances under which I wish to refuse the life sustaining treatments detailed above

I confirm that I would want to be given pain relief and/or be made as comfortable as possible in any event

I understand that I cannot refuse basic care

This form **must** be independently witnessed if any advance decision applies to the refusal of life sustaining treatment.

To be completed by the person making the advance decision to refuse life sustaining treatment	
Name	
Signature	
Date	

Appendix C

To be completed by the independent witness	
I confirm that I have witnessed this above named person sign this advance decision. I confirm that the above named person has made this advance decision of their own free will, without undue pressure or influence.	
Name	
Signature	
Relationship to the person making the advance decision to refuse life sustaining treatment	
Date	
To be completed by the clinician providing support and assistance	
I confirm that the person named above has capacity to make the decisions recorded above.	
The assessment of capacity to make the decision(s) above is/are recorded in; • RiO/SystemOne progress records dated…………………………………………… • RiO/SystemOne consent to treatment care plan………………………………... • Paper copy medical notes under section…………………………………………… • Other……………………………………………………………………………….	
Name	
Designation	
Date	

Appendix D

South West Yorkshire Partnership
NHS Foundation Trust

Advance Statement

This is my advance statement to be taken into account in deciding my best interests in case I am unable to participate in decisions about my treatment because of a lack of mental capacity.

Name:	
Address:	
Date of Birth:	
Distinguishing marks:	
Name of clinician with whom this was discussed:	
Designation of clinician with whom this was discussed:	
Date:	
Clinicians contact Address:	
Clinicians contact Tel No:	
GP:	
GP contact details:	
Other professionals consulted and purpose	

Appendix D

South West Yorkshire Partnership
NHS Foundation Trust

Name of; family members, friends, advocates, professional or others as identified who know, and understand about this advance statement.

In case of the need to make a best interests decision, I would like to have those individuals marked with an * to be consulted. He/she has given permission to be contacted and consulted as to their knowledge of my wishes, beliefs, preferences and values.

Contact Name	Contact Address	Contact Tel Number	Does the contact have a copy of the advance statement?

You should note that these statements are not legally binding, but should be taken into account when decisions are being taken regarding your care and treatment when you lack mental capacity to make such decisions.

Appendix D

South West Yorkshire Partnership NHS
NHS Foundation Trust

Details of my advance statement

In the event that I lack mental capacity to make decisions about my health care and treatment I provide the following information regarding my views, wishes, preferences and beliefs to be taken into account in the planning of my care and treatment in my best interests.

I understand that my advance statement is not legally binding but that but should be taken into account when decisions are being taken regarding your care and treatment when you lack mental capacity to make such decisions.

Advance Statement Regarding Medication and Treatment

My wishes regarding medication and treatment are as follows: (It is helpful to give reasons why)
When I was receiving care before, the following worked well for me:
Things that have not worked well in the past are:

Advance Statement regarding my Personal and Home Life

Consultation

I would like the following people to be told immediately that I have been admitted to hospital
Other people to contact and tell that I am not at home, e.g. milkman/home-help/work

I would like the following people NOT to be told
I would like to be consulted before people are told how I am etc

Personal matters

How I prefer to take my medication (time of day, as tablets, as injections etc)
Dietary requirements (food allergies, type of diet, preferred foods or drinks, disliked foods or drinks)
Religious beliefs and practices
How I prefer to dress/my appearance (hair style, make-up, clothing etc)

Children and Dependents

I have made the following arrangements for the care for my children or dependants as a short term measure
When someone explains where I am to my children or dependants I would like them to be told the following

Pets

I have made the following arrangements for the care for my pets as a short term measure

Security and my Home

I would like the following person to make sure my home is secure
I would like the following named person to hold a set of keys to my home
The following named person has agreed to check my mail

Additional information about my views, wishes, preference and beliefs

My past (things that are important to who I am – my work, where I have lived, holidays, special places)
My family

Things I enjoy (reading, tv shows, crossword, talking, going for walks, smoking, socialising, being alone etc)
Other

I understand that I cannot refuse basic care

I confirm that I am 18 years of age or older and understand that this document remains effective until I make it clear my wishes have changed. (The wishes of people under 18 years will be taken into consideration but are not legally binding)

Completed by the person making the advance decision	
Signed:	
Name:	
Date:	

To be completed by the clinician providing support and assistance	
I confirm that the person named above has capacity to make the decisions recorded above.	
The assessment of capacity to make the decision(s) above is/are recorded in; • RiO/SystemOne progress records dated……………………………………… • RiO/SystemOne consent to treatment care plan………………………………... • Paper copy medical notes under section……………………………………… • Other…………………………………………………………………………….	
Name:	
Designation:	
Date:	

Appendix E

Equality Impact Assessment Tool

To be completed and attached to any policy document when submitted to the Executive Management Team for consideration and approval.

Date of Assessment: 11/4/2018

	Equality Impact Assessment Questions:		Evidence based Answers & Actions:
1	Name of the document that you are Equality Impact Assessing		Mental Capacity Act 2005
2	Describe the overall aim of your document and context? Who will benefit from this policy/procedure/strategy?		Policy and guidance for Trust staff to follow in relation to Mental Capacity Act. Guidance from MCA Code of practice
3	Who is the overall lead for this assessment?		Director of Nursing and Quality
4	Who else was involved in conducting this assessment?		Assistant Director of Nursing and Clinical Legislation Manager
5	Have you involved and consulted service users, carers, and staff in developing this policy/procedure/strategy? What did you find out and how have you used this information?		Sent out for comment to Medical workforce Members of Trust policy group Members of Clinical Governance group Information Governance lead Director of Nursing and Quality Medical Director
6	What equality data have you used to inform this equality impact assessment?		This policy impacts on everyone therefore no equality data required.
7	What does this data say?		N/A
8	Taking into account the information gathered above, could this policy /procedure/strategy affect any of the following equality group unfavourably:	Yes/No	Evidence based answers & actions. Where negative impact has been identified please explain what action you will take to remove or mitigate this impact.
8.1	Race	No	N/A
8.2	Disability	No	N/A
8.3	Gender	No	N/A

	Equality Impact Assessment Questions:		Evidence based Answers & Actions:
8.4	**Age**	No	N/A
8.5	**Sexual orientation**	No	N/A
8.6	**Religion or belief**	No	N/A
8.7	**Transgender**	No	N/A
8.8	**Maternity & Pregnancy**	No	N/A
8.9	**Marriage & Civil partnerships**	No	N/A
8.10	**Carers*Our Trust requirement***	No	N/A
9	**What monitoring arrangements are you implementing or already have in place to ensure that this policy/procedure/strategy:-**		Checks to see if practice embedded through internal CQC visits, Mental Capacity Act audit. External CQC visits
9a	**Promotes equality of opportunity for people who share the above protected characteristics;**		As above.
9b	**Eliminates discrimination, harassment and bullying for people who share the above protected characteristics;**		As above.
9c	**Promotes good relations between different equality groups;**		As above.
9d	**Public Sector Equality Duty – "Due Regard"**		As above.
10	**Have you developed an Action Plan arising from this assessment?**		N/A
11	**Assessment/Action Plan approved by**		**Date:** 11 April 2018 **Title:** Director of Nursing and Quality
12	***Once approved, you must forward a copy of this Assessment/Action Plan to the partnerships team:*** **partnerships@swyt.nhs.uk** **Please note that the EIA is a public document and will be published on the web.** **Failing to complete an EIA could**		

	Equality Impact Assessment Questions:	**Evidence based Answers & Actions:**
	expose the Trust to future legal challenge.	

If you have identified a potential discriminatory impact of this policy, please refer it to the Director of Corporate Development or Equality and Engagement Development Managers together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact the Director of Corporate or Equality and Engagement Development Managers.

Appendix F Checklist for the Review and Approval of Procedural Document

To be completed and attached to any policy document when submitted to EMT for consideration and approval.

	Title of document being reviewed:	Yes/No/ Unsure	Comments
1.	**Title**		
	Is the title clear and unambiguous?	YES	
	Is it clear whether the document is a guideline, policy, protocol or standard?	YES	
	Is it clear in the introduction whether this document replaces or supersedes a previous document?	YES	
2.	**Rationale**		
	Are reasons for development of the document stated?	YES	Review due
3.	**Development Process**		
	Is the method described in brief?	YES	
	Are people involved in the development identified?	YES	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	YES	
	Is there evidence of consultation with stakeholders and users?	YES	
4.	**Content**		
	Is the objective of the document clear?	YES	
	Is the target population clear and unambiguous?	YES	
	Are the intended outcomes described?	YES	
	Are the statements clear and unambiguous?	YES	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	YES	
	Are key references cited?	YES	
	Are the references cited in full?	YES	
	Are supporting documents referenced?	YES	
6.	**Approval**		
	Does the document identify which committee/group will approve it?	YES	
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	N/A	

	Title of document being reviewed:	Yes/No/ Unsure	Comments
7.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	N/A	Training is mandatory
	Does the plan include the necessary training/support to ensure compliance?	N/A	Trainning is mandatory
8.	**Document Control**		
	Does the document identify where it will be held?	YES	
	Have archiving arrangements for superseded documents been addressed?	YES	
9.	**Process to Monitor Compliance and Effectiveness**		
	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	N/A	
	Is there a plan to review or audit compliance with the document?	YES	MCA audit, internal and external CQC visits
10.	**Review Date**		
	Is the review date identified?	YES	
	Is the frequency of review identified? If so is it acceptable?	YES	
11.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible implementation and review of the document?	YES	

CHANGES TO MCA POLICY GUIDANCE

INSERT ,**decision making and forward care planning**.

INSERT - **our mental health and learning disability services**

INSERT - **those of the Mental Capacity Act when considering the patient's**

REMOVE – consent provision for those patients who have capacity

INSERT - **Once it is confirmed that the person lacks capacity to make the decision the act done for, to or on behalf of the person must be clearly determined to be in their best interests and clearly recorded**

INSERT - **Greater weight is to be given to the values, wishes, beliefs and preferences when making the best interests decision**

INSERT - **for a time in the future when they may lack capacity to make a range of decisions**

INSERT - **The Act sets out details for the Independent Mental Capacity Advocate (IMCA), which is the statutory advocacy service for people who lack capacity. In certain circumstances an IMCA must be**

instructed by staff working with the person and their findings must be taken into account when making the decision

6 INSERT - Consenting to marriage or **civil partnerships**

INSERT - **Voting**

Where a person is subject to the MHA the requirements of Part 4 or Part 4A (as applicable) must be followed for treatment of mental disorder

Nothing in the Act is to be taken to affect the law relating to murder, manslaughter or assisting suicide

INSERT - **to make decisions regarding his treatment.**

9.4 A persons capacity to make a decision must never be based simply on;

their age their appearance assumptions about their condition, or any aspect of their behaviour

INSERT - **The Trust has a form which can be used to record assessments of capacity. This can be accessed through the Trust MCA intranet page**

INSERT - **Any such record should state what attempts were made to enable the person to participate in the decision, what information was provided, what the decision was and, if the patient lacks capacity, on what grounds the patient lacks capacity.**

INSERT - **10.3 This record should include a statement as to whether the patient is**

expected to regain capacity if the decision can be deferred until such

a time as the patient regains capacity and what, if any, steps or interventions need to be taken to enable the person gain or regain capacity to make the decision

10.4 Assessments of capacity should be supported by a consent care plan held in the patients electronic records. The care plan should include details of where to find the record of the assessment and the date of the assessment.

INSERT - 10.5 **If a decision needs to be made at the time then the best interest decision**

should also be recorded. A copy of the Trust best interest decision form can be found at Appendix B or in the Trust MCA intranet pages

INSERT - 10.6 **All best interest decisions should be supported with care plan held in their patients electronic records.**

12.2 – INSERT - **and benefits**

12.4 – INSERT -). **Consideration for the use of the MHA 1983 should also be given in such circumstances, and may be applied to compel treatment for the direct consequence of an act of self-harm which is a manifestation of the mental disorder**

INSERT - 12.6 However, patients with capacity **do** have the right to refuse life-sustaining

treatment (other than for treatment of mental disorder under

the Mental Health Act 1983) – both at the time it is offered and for a time in the

future. Making a decision which, if followed, may result in death does

not necessarily mean that a person is or feels suicidal. Nor does it

necessarily mean that the person lacks the capacity to make the

decision now or in advance. If the person is clearly suicidal, this may

raise questions about their capacity to make the decision. **Further s.62 of the MCA is clear that others cannot be directed to assist a person in their attempt to commit suicide.**

If a patient with capacity has harmed themselves, a prompt psychosocial

assessment of their needs should be offered. However, if the person

refuses treatment and use of the Mental Health Act 1983 is not

appropriate, then their refusal must be respected. Similarly, if

practitioners have good reason to believe that a patient genuinely

intended to end their life and had capacity when they took that

decision, and are satisfied that the Mental Health Act is not applicable,

then treatment should not be forced upon the person, although clearly

attempts should be made to encourage them to accept help. **The Trust form for the recording of an advance decision to refuse life sustaining treatment is contained within the Trust advance decision form and can be found at Appendix C And on the Trust MCA intranet page**

INSERT **- What information was used including how you considered the persons views, wishes and beliefs**

INSERT - 18.1 Local Authorities are responsible for the commissioning of Independent

Mental Capacity Advocacy Services (IMCA). The organisation the **Trust MCA intranet page is linked to the SCIE website which maintains an up to date data base of IMCA services and their contact details.**

20.4 The personal welfare LPA can only be used when the person who created

it lacks capacity **and ceases to have effect once the person regains capacity to make their own health and welfare decisions.**

INSERT - 20.16 Employees of the Trust must not agree to be an Attorney for a service

user for whom they are providing care, treatment or support. In order to

avoid the possibility of members of the patient's family raising issues

about the reason for and nature of the involvement of staff, Trust

employees should not assist with the wording of an LPA but rather direct or support the patient to seek legal advice. **Trust staff may, if satisfied of the person's capacity to make the LPA, sign the capacity certificate contained within the application. A full record of the assessment of capacity should be made within the electronic patient record.**

INSERT - 21.1 Previously commonly known as living wills, or advance directives, these

documents existed prior to the enactment of the Mental Capacity Act. The

MCA clarifies the legal status of these decisions, now known as Advance

Decisions, Advance Statements and Advance Decision to refuse Life

, when they have the capacity to make the decision, make an advance decision to refuse specified treatment (but not basic care – see paragraph 19.9 below**) under specified circumstances for a time in** the future **when the treatment may be considered to be an option. The refusal of treatment can extend to** include **the** refusal of life sustaining treatment.

INSERT 21.2 An advance decision to refuse treatment can only be made by a person

aged 18 or over who has mental capacity at the time the advance decision

is made. If the advance decision is valid and applicable, then it has legal

force. An advance decision may be verbal or in writing whilst an advance

decision to refuse life sustaining treatment must be in writing. It must be

signed by the maker in the presence of a witness who must also sign it. **Trust staff must not act as the independent witness to the advance decision to refuse life sustaining treatment.** It can be in any format and **a copy should** be in the person's medical notes. (see refusing. **The Trust form for the recording of advance decisions including those which refuse life sustaining treatment can be found at Appendix C and on the Trust MCA intranet page**

INSERT - 21.6 Advance decisions to refuse life sustaining treatment must be verified by a

specific statement that says the advance decision is to apply to the specified treatment even if **the withholding of that treatment puts the person's** life at risk.

INSERT - 21.14 Advance decisions to refuse treatment for a mental disorder can be over

ruled by Part 4 of the MHA **but a record of the reason why the advance decision has been set aside must be made and the reasons explained to the person when they have regained capacity to make their treatment decisions.**

INSERT **21.14 When a person under the care of the Trust has been given a diagnosis of a life limiting illness Trust staff should advise the patient of the option for creating advance decisions.**

INSERT 22.0 Statements of wishes, feelings and beliefs

22.1 These are a formal way for an individual to make known his personal

desires in respect of his care and treatment. They assist family, friends,

and professionals determine best interests, should that person lose

capacity. It must be borne in mind that these are **not legally binding**

INSERT - **22.0 Statements of wishes, feelings and beliefs**

22.1 These are a formal way for an individual to make known his personal

desires in respect of his care and treatment. They assist family, friends,

and professionals determine best interests, should that person lose

capacity. It must be borne in mind that these are not legally binding. An individual

cannot demand that they are met. They can include anything that is

important to the person e.g. the need for a vegetarian diet, religious

practices, or the wish to have a pet looked after, or moved with the person

into residential care. They can also indicate the type of treatment a

person would like to have for a particular disorder, including specific drugs

or other treatments **that have been successful for the person in the past.**

22.2 Advance statements can work in conjunction with advance decisions, with a decision stating what treatment the person refuses and the statement providing guidance for previously effective treatment or preferred routes of administration of medication.

INSERT - **25.5 The Mental Health Act Code of Practice requires(25.56) that consultees inform the SOAD of any past and present views and wishes of the patient and that the SOAD should give due weight to them when making their decision to authorise treatment.**

INSERT - s62 MHA may override the advance decision to refuse ECT **should this become life sustaining treatment.**

25.7 The Mental Health Act 1983 as Amended by the Mental Health Act 2007

decision and LPA (health and welfare) in respect of **treatment for** community **(CTO)** patients

INSERT - 26.2 Parts of the Mental Capacity Act do not apply to young people aged 16and 17. A young person cannot make a Lasting Power of Attorney or an advance decision to refuse treatment. **However case law has shown that the closer the young person is to adulthood, the greater the weighting that is given by the Court to the young person's wish or preference. Where young people are approaching transition between children and adult services consideration should be given to supporting the young person to set out their views, wishes and preferences in respect of their care and treatment in order to facilitate a successful transition as outlined in NICE Guidelines**

INSERT **30.4 The Court of Protection has the option of issuing a s.49 direction. This court order requires that as part of their NHS duties staff are required to make assessment, provide treatments and reports to the Court to enable the court to make it's decision. In order that the Trust is able to comply with the**

Court Rules, all approaches for reports for the Court of Protection must be directed to Legal Services who can be contacted at swy-tr.section49@nhs.net.

INSERT - 32.13 **Those aged 16 and 17 sit outside the scope of the DoLS, however to care and treat a young person in circumstances which may amount to them being deprived of their liberty may require an application to the Court of Protection and Trust Legal Services must be notified as soon as practicable (swy-tr.legalservices@nhs.net)**

32.14 Those adults who are being cared for in settings which amount to them being deprived of their liberty but are not in a hospital or registered care home may require authorisation form the Court of Protection. Where such circumstances are suspected the clinical team must contact the Trust Legal Services for advice (swy-tr.legalservices@nhs.net)

Version Control Sheet

This sheet should provide a history of previous versions of the policy and changes made

Version	Date	Author	Status	Comment / changes
1	December 2008			
2	October 2010	Head of Legal Services	DRAFT	
3	February 2016	Assistant Director, legal services	Reviewed	None
4	April 2018	Assistant Director Legal Services	Reviewed	Changes to reflect case law and feedback from staff, list of inserted changes attached to this document