



Department
of Health

Mental Capacity Act 2005 in Practice

Learning Materials for
Adult Social Workers

Authors: Daisy Bogg, with Steve Chamberlain

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Foreword from Lyn Romeo, Chief Social Worker for Adults

The Mental Capacity Act (the MCA) empowers and protects individuals who may lack capacity to make decisions about their care and treatment. Its principles of person-centred, least restrictive care represent the very best of social work practice. Evidence shows that awareness and implementation of the MCA is poor in some parts of the country and some corners of the health and care system. Much work over the last year has been done to begin to address this problem. The CQC is paying much greater attention to the MCA during inspections and the Social Care Institute of Excellence has launched a new online MCA Directory containing many useful materials for professionals.

In my role as Chief Social Worker for Adults, I am particularly passionate about the real benefit the MCA can make to people's lives. I strongly believe that while implementing the MCA is everyone's responsibility, social workers have the expertise and capability to really build momentum and support for the culture of care the MCA makes possible. This CPD guide forms part of a package of work to help support social workers realise their full potential on the MCA. I would urge all social workers to consider how they might use this guide to reflect upon how you can develop your skills in supporting those individuals who may lack mental capacity.



Lyn Romeo

Chief Social Worker for Adults (England)

Learning outcomes

Reading and completing the activities in this module will support social workers to achieve the following learning outcomes:

- Understand the key principle of presuming capacity and identify how this can be and should be applied in practice.
- Identify the key aspects which may suggest that a person lacks capacity and how social workers should respond.
- Understand what is meant by mental capacity.
- Understand the capacity assessment process.
- Understand how the presumption of and assessment of capacity underpins the framework and links to social work practice.
- Identify further learning and development needs arising from the application of this first key principle.
- Understand what is meant by maximising capacity.
- Understand what is meant by supported decision making.
- Identify practical steps you can take to support communication and assist people to make their own decisions wherever possible.
- Understand the key principle of unwise decision making within the context of mental capacity.
- Identify and explore personal and professional values in relation to unwise decisions.
- Understand the responsibilities of professionals to support individual autonomy, even when the choices an individual makes are deemed unwise.
- Identify the difference between unwise decisions and the lack of capacity to understand or weigh information.
- Consider less restriction and understand how it applies to practice.

Introduction to the Mental Capacity Act 2005

The Mental Capacity Act (MCA) was developed to co-ordinate, bring together and simplify the law about the care and treatment of people who lack capacity. It builds on common law and is designed to protect the rights of individuals and to empower vulnerable people.

The Act introduced powers and organisations to protect individuals and helps to clarify what is expected of staff. In the past, it was not unusual for some people, for example people with severe or enduring mental health problems, to have decisions made for them. This resulted in numerous injustices, such as mass institutionalisation, forcible treatment, and loss of control of their own finances. It puts the needs and wishes of a person who lacks capacity at the centre of any decision making process.

The Chief Social Worker held a summit on the MCA in March 2015 bringing together social workers from across England with representatives of other disciplines and sectors including: NHS providers, NHS commissioners, high street banks, high street solicitors, third sector organisations and the police. The aim was to consider how social workers might link up with these organisations in joint working, to better implement the MCA for the benefit of service-users. The seminar made a number of recommendations key amongst them the need to work in partnership with others.

Who does the Mental Capacity Act 2005 cover?

It could include everyone at certain times, but certainly includes many people with whom social workers will be working. It provides a legal framework for acting and making decisions on behalf of people who lack the capacity to make decisions themselves, and covers adults over 16 years old, focusing on the principle that any decision made should be in people's best interest and should avoid overly controlling or restrictive decision making.

There are some decisions that can never be made under the Act by another person for someone who lacks capacity. Decisions that cannot be made on behalf of someone else include:

- whether to get married or have a civil partnership;
- whether to have sex;
- placing a child for adoption; and
- voting at an election.

This does not mean that capacity may not be considered in these situations, but rather if a person is assessed as lacking capacity in any of these areas a best interest decision may not be made on their behalf.

Useful information: Principles of the Mental Capacity Act 2005:

- ✓ A person must be assumed to have capacity unless it is established that they lack capacity.
- ✓ A person is not to be treated as unable to make decisions until all practical steps to help him do so have been taken without success.
- ✓ A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
- ✓ An act done or decision made under the Act for or on behalf of a person who lacks capacity must be done or made in his best interests.
- ✓ Before the act is done, or decision is made, regard must be had to whether the purpose for which it is needed can be effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

The MCA Everyday Processes

The Mental Capacity Act S.1(2) states that when considering capacity, a person should be assumed to have capacity until it is established that they lack capacity. Section 1(3) dictates that a person is not to be treated as lacking capacity, until ‘all practicable steps’ have been taken to assist them in the assessment process.

The Code of Practice (2007) offers a key definition of ‘a person who lacks capacity’:

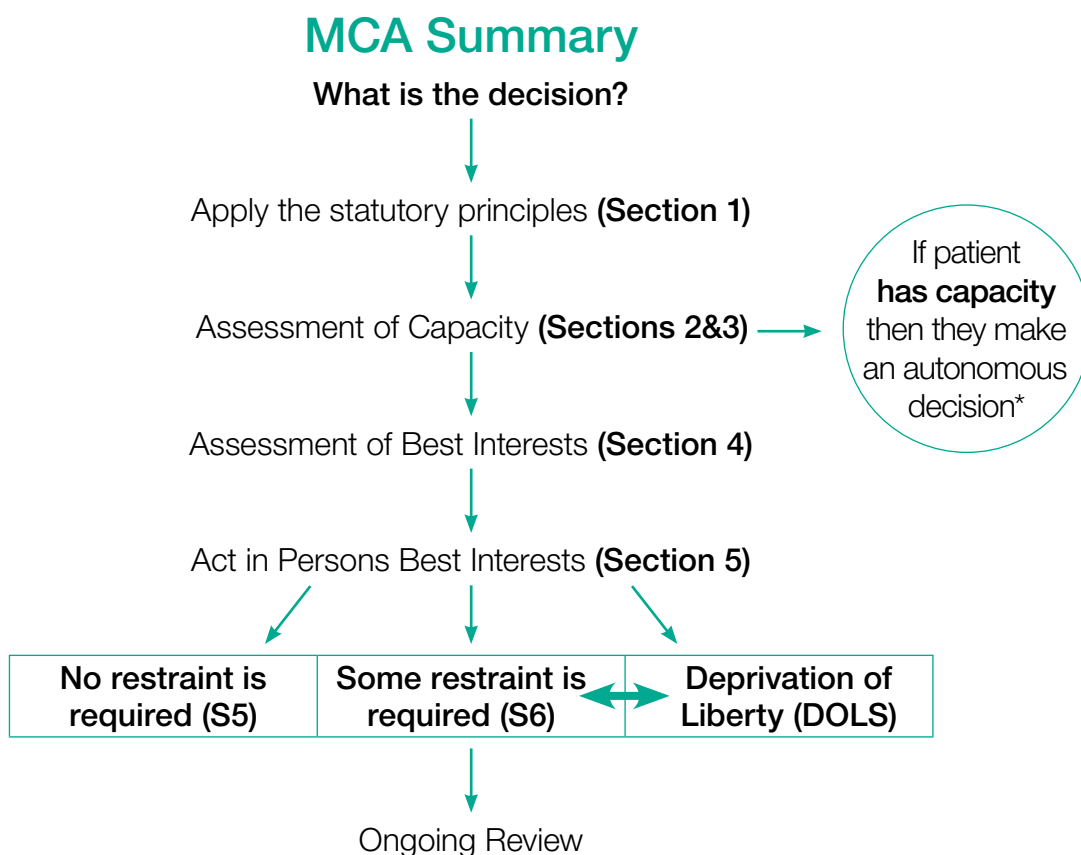
‘Whenever the term “a person who lacks capacity” is used, it means a person who lacks capacity to make a particular decision or take a particular action for themselves at the time the decision or action needs to be taken. (MCA Code 2007:3)

The decision-specific nature of the capacity process

As the assessment of capacity is decision specific, there should be no general statements regarding that a person ‘lacks capacity’ (Section 2(1)).

When does a social worker need to consider a person’s capacity?

Social workers working with adults should continually be aware of capacity in relation to specific decisions that vulnerable adults are required to make; particularly, where a specific decision make place themselves or others at risk (MCA Code 4.34). Social workers should also consider supporting adults to plan for any possible future loss of capacity through appointing delegated decision makers or recording their advance decisions and wishes (Hale, 2014).



Where a person has a mental disorder and there are risks to their health, safety or the protection of others, they can be detained or made subject to an order under the Mental Health Act. The courts also have a power under their 'inherent jurisdiction' where a vulnerable person is influenced by significant coercion in their decision making.

The Assessment of Capacity

This is set out in Section 2 and 3 of the Mental Capacity Act and guidance is provided in Chapters 3 and 4 of the MCA Code. For a person to lack capacity there are two linked tests; both tests must be met if the person is to be found as lacking capacity.

The 'Diagnostic Test' states that, to lack capacity, the person must be suffering from an impairment or disturbance in the functioning of the mind or brain (Section 2(1)). The 'Functional Test' (Section 3) seeks to assess whether the person can understand, retain, weigh and communicate information relevant to a particular decision. If they are unable to perform any of these functions then they will have *failed* this test.

The person must be facilitated to fully participate in the assessment and provided with sufficient information on viable care options to enable them to make a choice (CC v KK 2012). Additionally, Baker J, the Judge in the KK Case, concluded that when assessing capacity, the person need only to be able understand, retain and weigh information on the 'salient' points rather than the comprehensive details of the matter.

The decision in PC v City of York (2013) emphasised the need for a 'causative nexus' between the diagnostic and functional tests to ensure they explicitly relate to the relevant decision. This case related to a woman with significant learning disabilities who had decided to reside with a known sexual offender. When applying the functional test she was assessed as unable to weigh the risks. However, the judges concluded that this was due to her strong emotional attachment to her partner rather than her learning disability (or the impairment in the functioning of the mind or brain) and deemed that she had capacity to make this decision.

Who should be involved?

The MCA Code 4.51 to 4.54 suggests where the decision has serious consequences, or where the capacity assessment is contentious, it is appropriate to involve specialist professionals such as a psychiatrist, psychologist or speech therapist (in particular where the person has communication difficulties).

How should the capacity assessment be recorded?

For day-to-day decisions, it is appropriate to record the consideration and assessment of a person's capacity in their regular professional record. Examples of such decisions could include what clothes to wear, food to eat or whether to go for an accompanied walk (MCA Code 4.61). For contentious decisions or where the decision has serious consequences (such as accommodation choices, medical treatment and significant financial decisions) then it may be necessary to use a formal capacity assessment tool in accordance with the organisation's policy and procedures.

What are Best Interests?

There is not a single definition of what best interest means; social workers need to consider and take account of (CoP, para 5.18–5.28):

- Identifying all relevant circumstances.
- Encouraging participation.
- Finding out the person's views.
- Whether they will regain capacity.
- Whether there is an advance decision.
- Avoiding discrimination.
- Consulting others.
- Avoiding restriction of rights.

Best interests apply to financial decisions, personal welfare decisions and healthcare decisions, and the person who makes the decision should be the most appropriate person involved in that decision, except where a Lasting Power of Attorney or Deputy is in place.

There are two exceptions to best interest decision making: these are where an advance decision to refuse medical treatment exists and involvement in research which balances the burden and benefit of involvement in research (CoP, Ch 11).

There are special considerations that must be applied to best interest decisions that concern life-sustaining treatment. These are:

- Any advance decisions to refuse treatment that may be in place.
- Actions must not be motivated by a desire to bring about the person's death.
- No assumptions are made about the person's quality of life.
- All reasonable steps to prolong life are taken.

What are Advance Decisions?

An advanced decision is a refusal of specific medical treatment in certain circumstances. It has legal status under the Act and applies to decisions made when the person is over 18 years and has capacity. Where it concerns the refusal of life-sustaining treatment the advance decision should be in writing and witnessed.

An advance decision can be cancelled by the person or updated at any time while they have capacity. Professionals will need to consider the validity of an advance decision, considering:

1. Whether the person has done anything that goes against their decision.
2. Whether the decision has been withdrawn or changed.
3. Whether the decision has been conferred to an attorney.
4. Whether the person would have changed the decision if they had known about the current circumstances.

Acting in the Person's Best Interests

This is set out in Sections 5 and 6 of the Mental Capacity Act and guidance given in Chapter 6 of the MCA Code.

The protection from liability and limitations

Where a person has been assessed as lacking capacity to make a specific decision regarding their care and treatment, Section 5 of the MCA provides legal protection for a carer or professional to carry out an act in their best interests. The MCA Code 6.5 provides a list of the type of actions that this may include.

The definition of restraint, harm and the proportionate use of restraint

There may be occasions where it is necessary to use restraint, control or force to act in a person's best interests. Section 6(4) of the Mental Capacity Act and the MCA Code 6.40 provides a definition of restraint. The protection from liability offered by Section 5 does not apply where restraint is used. Section 6 of the MCA states that where restraint is used, protection from liability will only be granted where the person taking action believes the restraint is both *necessary* and *proportionate* to the risk of harm (MCA Code 6.41).

The limits of Section 6 and the interface with Article 5 Human Rights Act

Sections 5 and 6 of the MCA provide the legal authority to act in a person's best interests, including the necessary and proportionate use of restraint. However, these sections do not permit restraint or control to a degree which amounts to *detention* or what is defined under Article 5(1) of the European Convention on Human Rights as *Deprivation of Liberty*. A deprivation of liberty can only be authorised by the Court of Protection (Section 16(2) (a)), the Mental Health Act 1983, or the Deprivation of Liberty Safeguards (DoLS) (MCA Schedule A1).

Deprivation of Liberty – The Acid Test

The threshold for engaging Article 5(1) or a deprivation of liberty was clarified by the Supreme Court in the case of *P v Cheshire West and P and Q v Surrey CC* (2014). Lady Hale provided the 'acid test', which is that a person is deprived of liberty if they are not free to leave and they are subject to continuous supervision and control. Lady Hale indicated that the requirements for vulnerable persons to have access to legal safeguards are so important that professional should 'err on the side of caution' when determining whether a deprivation is occurring.

The lower threshold for engaging Article 5 echoes several judgements by the European Court at Strasbourg. In the cases of *Stanev v Bulgaria* (2012), *Kedzior v Poland* (2012) and *Atudorei v Romania* (2014) the European Court found that deprivations of liberty were occurring in situations where people were permitted significant periods of leave from the institutions where they resided. However, in each of these cases, the court found that, if necessary, the state authorities would have acted to return the person to the institutions and that this amounted to 'continual supervision'.

The DoLS safeguards can authorise a deprivation in a hospital or care home. Where a person lives in their own home or in a supported tenancy then an application must be made to the Court of Protection to authorise the deprivation, according to the procedure outlined in *Re X (Deprivation of Liberty)* 2014. In response to the House of Lords Post Legislative Scrutiny

Report, the Law Commission has been commissioned to review the DoLS safeguards and develop a procedure for the safeguards to apply to people in community settings.

Where there is an irreconcilable dispute regarding residence between professionals and a person lacking capacity and/or family it is not appropriate to rely on the DoLS safeguards. In such circumstances, it is necessary to apply to the Court of Protection for a decision regarding the Article 5 and 8 issues.

The Law Commission Review of DoLS

Since the 19 March 2014 the Deprivation of Liberty Safeguards (DoLS) processes have seen an exponential rise in application as the Supreme Court judgement, known widely as 'Cheshire West' re-established the 'acid test' and effectively lowered the threshold for deprivation. As a result of this and the House of Lords Post-Legislative Scrutiny report published shortly before, which levelled some damning criticism at both health and social care in relation to how the MCA 2005 was being implemented, the Department of Health asked the Law Commission to review the DoLS process and make proposals on a new legal framework that could be implemented to resolve some of the current debates and conflicts.

The Law Commission launched their report and consultation on 7 July 2015 and the consultation process closes on 2 November 2015, with the Law Commission intending to present a draft bill to Government in late 2016. The key recommendations are as follows:

- Replacement of DoLS with an inclusive 'protective care' scheme which focuses on safeguards and best interests in relation to accommodation, care and treatment for individuals assessed as lacking capacity to make the relevant decision. The scheme will be tiered to support application in different settings. Care plans will be the relevant authorisation for restrictions on and deprivations of liberty with specific capacity decisions identified for each scheme.
 - Supportive care – prevention focus: care homes, supported living and shared lives.
 - Restrictive care and treatment – restrictions and deprivations. Authorisation process: care homes, supported living, shared lives, domestic and family settings.
 - Hospital scheme – deprivations: hospitals and palliative care settings – streamlined to enable Doctors to apply for up to 28 days.
- Proposed principles to underpin the scheme are that it should deliver improved outcomes, and be based in the Mental Capacity Act, non-elaborate, compliant with the European Convention on Human Rights, supportive of the UN Disability Convention, and tailored according to setting.
- Align both the age thresholds and the definitions of mental disorder with those set out in the MCA, therefore:
 - All Provisions should apply to individuals aged 16 and over.
 - Definition applied should be *'impairment or disturbance in the functioning of the mind or brain'* to include conditions such as brain injury and vegetative state/unconsciousness etc in the protective care scheme.

- Replacement of the BIA role with an 'Approved Mental Capacity Professional' role, which mirrors the AMHP under mental health legislation in terms of powers and has an oversight role in relation to deprivations and more complex cases.
- Introduction of a tribunal system with specific appeal routes to upper tribunal and court of protection. Proposals include incorporation into current MHRT structure.
- Regulation of education and training for the AMCP role. Current BIAs would be able to convert to the new role as was the case with the transition from ASW to AMHP in 2007 under the amendments to the MHA 1983.
- Alignment of MCA and the Protective Care scheme with the provisions and entitlements under the Care Act 2014, with a care plan being the key authorising document for restrictions and deprivations rather than a separate set of bureaucratic processes.

The MCA/DoLS Interface with the Mental Health Act

One of the key challenges experienced by social workers and other professionals in the field has been how the interface between the mental capacity legislation and Mental Health Act legislation is applied. In response to this a new chapter was added to the Mental Health Act Code of Practice in early 2015, with the aim of clarifying the overlaps and supporting professionals in the field in decision making in this complex area.

The Mental Capacity Act 2005 applies to individuals in mental health settings as it does to individuals in other care settings. While some decisions can be made regardless of capacity and consent under the Mental Health Act this does not mean that these should not be considered and both frameworks emphasise the importance of involving the person and acting in a person's best interests.



For more guidance read Chapter 13 of the Mental Health Act Code of Practice (2015) Available at – https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF

The interface between the Mental Health Act and DoLS has become far more complex in practice, and while the MHA Code of Practice provides some guidance there remains a significant grey area that is being debated in case law at the current time. It is of note that the Law Commission proposals encompass this area and the suggestion is to separate Mental Health Act and Mental Health Act provisions to ensure it is clear how each should be applied.

What is an Independent Mental Capacity Advocate (IMCA)?

Anyone over 16 who lacks capacity and does not have anyone to support and represent them is entitled to the support of an IMCA. This applies to decisions about accommodation or care moves, serious medical treatment, adult protection procedures and care reviews. The IMCA is independent of the person making the decision and has a focus on the person's best interests. The IMCA has four key functions:

1. Ascertaining the views, feelings, wishes, beliefs and values of the person using whichever communication method is preferred and ensuring that those views are communicated to, and considered by, the decision maker.
2. Asking questions on behalf of the person and representing them. Making sure that the person's rights are upheld and that they are kept involved and at the centre of the decision-making process.
3. Investigating the circumstances. Gathering and evaluating information from relevant professionals and people who know the person well.
4. Auditing the decision-making process. Checking that the decision maker is acting in accordance with the Act and that the decision is in the person's best interests. Challenging the decision if necessary.

Under the Care Act 2014 an individual who has significant difficulties engaging with the assessment and support planning processes (including those with issues relating to their capacity to consent to assessment or support) and statutory guidance has made it clear that this role and the role of IMCA may be undertaken by the same advocate. The Law Commission proposals (2005) on the reforms needed to the MCA and DoLS include proposals to combine these roles more formally.

What is a Lasting Power of Attorney (LPA)?

The Act enables people to appoint someone to make decisions on their behalf for a time when they lack capacity. The chosen attorney can only make decisions for the person if it is in their best interests, and a person can only make an LPA when they have capacity and that LPA must be registered with the Office of the Public Guardian.

There are two types of LPA:

- 'Property and affairs' which replaces the previous Enduring Power of Attorney to make financial decisions on behalf of the person if they lose capacity in this area.
- 'Personal welfare' which is a new way to appoint someone to make health and welfare decisions.

Useful Information: Identifying a LPA

If an individual holds a LPA they are able to make decisions and consent on behalf of the person in the areas that the LPA covers.

LPAs are registered with the Office of the Public Guardian:

<http://www.justice.gov.uk/about/opg>

Additional Guidance is also available at:

<https://www.gov.uk/government/publications/register-a-lasting-power-of-attorney>

What can be done under Sections 5 and 6 of the Mental Capacity Act 2005?

Section 5 of the Act provides a framework for acts in connection with care and treatment that can be applied if a person is assessed as lacking capacity and a decision needs to be made

in their best interests (as defined by the Act, see information later in these materials for more details on best interest decisions).

A range of interventions is included in the Act; including (but not limited to):

- assistance with physical care, e.g. washing, dressing, toileting, changing a catheter, colostomy care;
- help with eating and drinking;
- help with travelling;
- shopping;
- paying bills;
- household maintenance;
- administering medication;
- diabetes injections;
- diagnostic examinations and tests;
- medical and dental treatment;
- nursing care;
- emergency procedures; and
- invasive medical procedures including surgery.

Section 6 of the Act also allows professionals to use restraint in situations where an individual is resisting interventions, but only if it is considered to be proportionate to the risks presented. This does not mean that you are able to deprive an individual of their liberty under the Act; if this is required then a different framework, for example DoLS or the Mental Health Act 1983 may be required.

Useful Information: Sections 5 and 6 Mental Capacity Act 2005.

MCA Section 5 acts:

The professional must first take reasonable steps to establish if the person lacks capacity, must believe that he does and that they are acting in the person's best interests.

Section 6:

Restraint of the person is permissible only if necessary to prevent harm to P and is proportionate to the likelihood and seriousness of harm BUT restraint must not amount to deprivation of liberty.

What is the Court of Protection?

The Court of Protection is a specialist court for all issues relating to people who lack capacity. It has several core functions; these include:

- making decisions;
- arbitrating in cases where there are disputes and differing opinions; and
- appointing deputies.

More information can be found at:

<https://www.gov.uk/apply-to-the-court-of-protection>

It is governed by the Court of Protection Rules 2007 and 2011, and practice directions which can be found here:

<https://www.justice.gov.uk/courts/rcj-rolls-building/court-of-protection>

Principle 1: Assuming Capacity

Respecting and maximising an individual's capacity to make a decision is a core consideration in social work practice (Bogg, 2010) and practitioners need to be equipped to both understand the application of principle 1 and to make robust assessments regarding an individual's capacity where there is evidence to suggest it might be an concern.

Principle 1: A person must be assumed to have capacity unless it is established that they lack capacity. (MCA 2005; Section 1(2))

This principle focuses on the presumption of capacity in practice and supports social workers to apply the two-stage capacity assessment appropriately where it is appropriate to do so.

While these materials are designed to dip in and out of, you might want to take a little time to consider the following questions before reading further. This will help you to think about how you currently view mental capacity and how it might impact on your decision making and general practice capabilities.

Reflective exercise:

- *How do you currently define and assess capacity? Does this reflect the two-stage test set out in the legislation?*
- *What does this first principle mean to you and how do you ensure you apply it in practice? Try and think of specific examples where you have done this when working with individuals.*

Principle 2: Supported Decision Making

Supporting people to make their own decisions is a key element in social work practice. It is embedded in the Professional Capabilities Framework (rights of autonomy and self-determination). Social workers need to work to enable everyone with whom they work to

make decisions for themselves whenever possible, irrespective of their level of disability or cognitive impairment.

Principle 2: A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
(MCA 2005; Section 1(3))

Sometimes people choose to make decisions which social workers or other professionals may consider unwise or irrational and you must be aware of the importance of the rights of individuals to make those decisions, and always be aware of the balance between the powers that exist to take action to protect a person from harm and a person's right to autonomy.

Reflective exercise:

- *How do I currently support people to make their own decisions?*
- *What does the second principle mean to me, and how do I ensure that before I complete an assessment of capacity for a particular decision, I am satisfied that I have taken all reasonable steps to support the person to make the decision for themselves?*
- *Try to think of some specific examples of when you have supported a person to make a decision for him or herself and concluded that they had capacity to make that decision (or did not have capacity in relation to that decision).*

Principle 3: Unwise Decisions

Within this principle it is important that social workers focus on their own values and professional codes of conduct to ensure that they do not presume a lack of capacity just because a person is making a decision they consider to be unwise or otherwise detrimental.

Each person's experience is different and just because someone chooses a particular path, which is perceived by professionals to be risky, this does not mean they have a right to intervene and stop the person making that decision. However, it is also important to not prejudge particular groups or decisions as unwise without considering whether the person is able to properly consider the risks they may face.

Principle 3: A person is not to be treated as unable to make a decision merely because he makes an unwise decision. (MCA 2005; Section 1(4))

This principle focuses on how social workers should respond to decisions that may be deemed unwise decisions. Paragraph 4.30 of the Mental Capacity Act 2005 Code of Practice makes it clear that it is important for professionals to '*acknowledge the differences between unwise decisions... and decisions based on a lack of understanding of risks or the inability to weigh up the information about a decision*' (DCA, 2007).

Reflective exercise:

- *How do you currently identify whether a decision is unwise or is as a result of a lack of capacity?*
- *How does the assessment that an individual is making an unwise decision affect your responses/interventions with that individual?*
- *How do you ensure your own values and beliefs do not define your responses to certain types of decisions in practice?*

Principle 4: Best Interests

This principle focuses on the area of best interests: a key focus of the Mental Capacity Act is that anything you do as a professional on behalf of an individual needs to be in their best interests. This does not mean that health and safety or other concerns are paramount over other considerations; the principle focuses on what the person themselves would decide if they could and draws on the views of others involved in order to make the best possible decisions where an individual is unable to decide themselves due to a lack of capacity in relation to that decision.

Principle 4: An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
(MCA 2005; Section 1(5))

Best interests are not specifically defined, however the Act and Code of Practice set out a checklist that assists social workers to work within best interests, ensuring that decisions are made after involvement and consultation with all the required individuals, and consideration is made of the wide range of factors considered necessary in the legislation.

Reflective exercise:

- *What does the fourth principle mean to me and how do I ensure that I consider all the relevant circumstances of the individual?*
- *How do I ensure the incapacitated person remains involved in the process to the maximum extent, given that person's level of disability?*
- *How do I explain the best interests decision making process to family members and carers, clarifying the limits of their involvement?*
- *Try to think of a specific example of making a best interests determination when there were conflicting views expressed, and how you managed to come to a decision having taken all the views into consideration.*

Principle 5: Less Restriction

The fifth key principle of the MCA is known as the ‘least restrictive option’. This principle is designed to assist social workers when making decisions on behalf of a person who lacks capacity to make that decision, to always consider whether the action proposed is the least restrictive, and if there is an alternative that is less restrictive of the person’s freedoms.

Principle 5: Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person’s rights and freedom of action. (MCA 2005; Section 1(6))

This is now reflected in all key social and health care legislation.

Care Act 2014 s1(3)

In exercising a function under this Part in the case of an individual, a local authority must have regard to the following matters in particular –

- (h) the need to ensure that any restriction on the individual’s rights or freedom of action that is involved in the exercise of the function is kept to the minimum necessary for achieving the purpose for which the function is being exercised.

Mental Health Act 1983 Code of Practice (2015)

1.5: Any restrictions should be the minimum necessary to safely provide the care or treatment required having regard to whether the purpose for the restriction can be achieved in a way that is less restrictive of the person’s rights and freedom of action.

Mental Capacity Act Principles Checklist	
Principle 2 ‘Practicable Help’	How did you support them to make the decision themselves? (e.g. tried later, explained, visual prompts, etc.)
Principle 3 ‘Unwise Decisions’	Remember that if they can think through the consequences then they are able to make the decision even if it is unwise. Describe if you think they can do this.
Mental Capacity Test	Do you think the person can make the decision? Why? (do they understand, can they think through the consequences and tell you their decision?)
Principle 4 ‘Best Interests’	If they can’t decide – how did you decide in their best interests? (How did you involve the person and take account of their views, who have you talked to, what are the options?)
Principle 5 ‘Least Restrictive’	How did you make sure that they still had as much choice, independence, privacy and freedom as possible?

What is Capacity?

Mental capacity is the ability to make a decision; it can vary over time and depending on the decision to be made. Physical conditions, such as location, can affect a person's capacity and it should not be assumed that someone lacks capacity due to a person's age, physical appearance, condition or an aspect of their behaviour. A person may also lack capacity to make a decision about one issue but not about others and a lack of capacity in any area does not have to be permanent. The Act defines capacity as:

'A person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or the brain.' (Section 2 (2)).

An impairment of the mind or brain can include a wide range of difficulties, illnesses and/or conditions; the Code of Practice provides some helpful guidance on this issue. (See paragraph 4.11–4.12 of the Mental Capacity Act 2005 Code of Practice (DCA, 2007) for details.)

The law makes it clear that professionals need to consider two key questions, firstly can the person make a decision for themselves, also known as the functional test, and if they cannot is this because of 'an impairment of, or disturbance in the functioning of the mind or brain', also known as the diagnostic test.

A person can lack capacity to make a decision at the time it needs to be made even if:

- the loss of capacity is partial;
- the loss of capacity is temporary;
- their capacity changes over time.

They may also lack capacity to make some decisions and not others.

Learning activity: Decision Specific Capacity

When planning for her retirement Mrs Harrison made a Lasting Power of Attorney and registered this with the Office of the Public Guardian. This related to her property and financial affairs and conferred decision making to her son to manage these if she ever lost capacity to manage them herself. She has now been diagnosed with dementia and her son is concerned that she is becoming confused about money.

- What must her son assume?

Mrs Harrison's son goes shopping with her and sees she is capable of finding products and making sure she gets the right change. However when talking over her investments and bills she becomes confused, even though she has made such decisions in the past. Her son tries to explain the options to her but she becomes distressed and says she doesn't want to worry about these at the moment.

- What might Mrs Harrison have the capacity to decide?

When assessing capacity you must do everything you reasonably can to help the person make the decision, including considering the support the person may need to assist them to make the decision, and avoiding using undue pressure or influence to decide one way or another.



The starting point for any social work interaction or intervention should be the presumption that the individual is able to make his or her own decisions.

What Capacity is not

Mental Capacity is a term that has been used by professionals for many years and there are many customs and practices that are no longer appropriate ways by which capacity should be measured.

Useful information: What Capacity is NOT...

- The ability to do a task.
- Having insight into your own condition.
- Having a mental illness, dementia, learning disability, brain injury or other impairment or disability.
- A test of memory, or measure of cognitive performance.

A person cannot be assessed as having a global lack of capacity and any decisions and assessments made by professionals should follow, and where appropriate evidence, the two-stage test of mental capacity.

Reflective exercise:

Thinking about your own practice and the practice of other professionals that you have observed:

- *What types of conditions/presentations have you observed that led*
- *professionals to make assumptions about an individual's capacity? How might you challenge these assumptions in the future?*

Presuming Capacity

In the case of mental capacity the presumption should always be in the first instance that a person has the ability, and hence the right, to choose for themselves and only where there is a concern or some evidence which would suggest otherwise are social workers prompted to consider assessment of an individual's capacity.

Useful information: A presumption of capacity.

- ✓ Every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise.
- ✓ This means that you cannot assume that someone cannot make a decision for himself or herself just because they have a particular medical condition or disability.

This is set out in the Act itself as principle 1 and is the area that the House of Lords (2014) highlighted as being commonly misunderstood and misapplied in professional practice. The House of Lords were very critical of professionals' application of this key principle in practice, stating that:

'The presumption of capacity in particular, is widely misunderstood by those involved in care. It is sometimes used to support non-intervention or poor care, leaving vulnerable adults exposed to risk of harm.' (paragraph 105)

The reasons why this might be the case was further explored in the 2014 post-legislative scrutiny report, leading to the conclusion that this situation was as a result of both misunderstanding and an attempt to avoid taking responsibility in cases where an individual's choices and risks were seen as challenging (HoL, 2014).



The House of Lords report (2014), including the complete set of recommendations can be downloaded from:

<http://www.publications.parliament.uk/pa/ld201314/ldselect/ldmentalcap/139/139.pdf>

This first principle of the MCA 2005 is embedded within our basic Human Rights. For anyone to intervene or interfere with a person, or their property, without valid consent from the individual, needs to follow the procedure prescribed by law (HRA 1998), which allows this, otherwise it is considered to be a major infringement of a person's civil liberties.

Useful information: Defining Valid Consent

Valid consent means that the individual is able to understand, weigh (or use) and retain the information they need to make a specific decision at a specific time.

Capacity cannot be assumed based on a person's condition, diagnosis, appearance, age, behaviour or capacity to make other decisions, it is a specific criterion that social workers need to apply to each situation where capacity is a potential concern.

Within the Mental Capacity Act 2005, capacity is defined as a time-specific and decision-specific consideration. This means that social workers will need to think about the decisions that they are making in relation to an individual's care and/or support on an ongoing basis, considering whether the person is able to provide what is known as 'valid consent' to the interventions they or other members of the multidisciplinary team are suggesting.

Reflective exercise:

Thinking about your own practice and the practice of other professionals that you have observed:

- *What assumptions have you/your colleagues made when an individual is considered to be engaging in risky or unwise behaviour but is presumed to have capacity to make that decision?*
- *How might you support individuals in these types of situations in the future?*

What might trigger a capacity assessment?

People are diverse: sometimes decisions that may seem unwise to professionals make sense and are in the best interests of the person making them and as such social workers and other professionals should not presume that an unwise decision is a reason to assess capacity – it is not. The judges are very clear on this point and social workers will need to consider their own values and prejudices as part of professional practice to ensure that they are not jumping to conclusions just because a person appears to be engaging in unwise or otherwise ‘risky’ behaviour.

Useful information: Judicial Views

‘It is... the essence of humanity that adults are entitled to be eccentric, entitled to be unorthodox, entitled to be obstinate, entitled to be irrational. Many are.’
(Davies, L.J in *DL v A Local Authority* [2012] EWCA Civ 253, para 76)

‘... there is a space between an unwise decision and one which the individual does not have the mental capacity to take.’
(McFarlane, L.J. in *PC v City of York* [2013] EWCA Civ 478, para 54)



Remember! *The starting point for any social work interaction or intervention should be the presumption that the individual is able to make his or her own decisions.*

A capacity assessment should only be triggered where there is evidence to suggest that capacity might be an issue in relation to a particular decision that needs to be made. This might include situations such as:

- The person’s behaviour or circumstances cause doubt as to whether they have the capacity to make a decision.
- Someone is concerned about the person’s capacity.

- The person has previously been diagnosed with an impairment or disturbance which has been shown to impact on their capacity to make some decisions (DCA, 2007; para 4.35)

Reflective exercise:

Thinking about your own practice and the practice of other professionals that you have observed:

- *In what situations and circumstances have you identified that a capacity assessment is needed?*
- ✓ It is important to ensure that you do not approach decisions from the presumption of a lack of capacity. It is a key social work responsibility to apply the guiding principles of the Mental Capacity Act in all practice decisions and interventions.

Learning activity: Triggering a capacity assessment

Which of the following scenarios would indicate to you that a capacity assessment is required; why do you think this is the case?

- Mary is in the early stages of vascular dementia; she lives at home with her husband and a small Jack Russell called Shane. She struggles with her short-term memory sometimes but has started writing lists and notes to herself to help her remember important things, dates and tasks. Increasingly she becomes confused towards the end of the day when she is tired but is aware of this and takes care not to overtire herself. Mary has developed a urinary tract infection and needs antibiotic treatment.
- Jenny has severe learning disabilities, she has limited verbal communication and when distressed bangs her head against walls and furniture. She is able to make basic choices about day-to-day decisions such as what she wants to wear, the food she eats and personal care tasks but has previously been assessed as lacking capacity in relation to consenting to attend day services and is only able to communicate by making noises or non-verbal responses.
- Simon is 25 years old; he has lived in local authority care since he was five years old. He has cerebral palsy and Asperger's syndrome. He had a number of foster placements but these broke down as a result of Simon presenting with challenging behaviour. He is currently living in a residential unit but finds it frustrating and boring and says he wants to live on his own.

Who should assess Capacity?

There is no requirement for that person to have undertaken formal training, however it is also noted that professionals will be undertaking fuller assessments in relation to more complex decisions and specifically in relation to health and social care support and treatment decisions (DCA, 2007).

The Act, and its Code of Practice (DCA, 2007), states that the person who is most appropriate should be the one to undertake the capacity assessment if there is a reason to doubt whether the person has the capacity to provide valid consent to any given decision.

This means that you should consider the nature of the decision to determine who is most appropriate to undertake the assessment, for example for social care decisions it is likely to be the social worker who is the appropriate decision maker, in medical decisions it is likely to be the doctor and in day-to-day decisions it is likely to be the person providing the care and support.

Learning activity: Identifying the appropriate decision maker

Read the vignette below and identify what factors you think would indicate that a capacity assessment was needed, who is the most appropriate decision maker in each case and who should be involved in the decision concerning any interventions that may be required.

- Charles is a 37-year-old man who has a diagnosis of autism. He currently lives in a small group home and is supported by care staff. He has limited verbal communication and has been assessed as lacking capacity in previous healthcare decisions (for example capacity to consent to blood tests being taken and capacity to provide consent for antibiotic treatment during a recent chest infection). Charles has been complaining of severe toothache over the last four weeks using both verbal and non-verbal communication to tell staff that he is in pain. Staff have made him several appointments at the dentist however he has refused to go on each occasion. Pain killers have been provided, however Charles is becoming more distressed and was found by staff the previous night attempting to extract his own tooth with a piece of string attached to a door handle.

Good practice guidelines suggest that where there are a number of professionals and/or supporters involved in a person's support, shared decision making is established. While the decision maker may remain responsible for implementing the decision, full involvement of the person and consulting the people who know the individual best will ensure that decisions are made in line with the 'best interests' of the person concerned.

Fluctuating Capacity

Mental capacity in many situations is not a fixed state. People with a range of needs and vulnerabilities are likely to have fluctuating capacity in that sometimes they may be capable of making their own decisions and some times they may not.

Useful information: Checklist Fluctuating Capacity (Section 2(2))

- ✓ The impairment or disturbance does not have to be permanent.
- ✓ A person can lack capacity to make a decision at the time it needs to be made even if the loss of capacity is partial, the loss of capacity is temporary, their capacity changes over time.
- ✓ A person may also lack capacity to make a decision about one issue but not about others.

Conditions such as mental ill health, dementia and other problems like, for example, infections, intoxication, low/high blood pressure or hypoglycaemia (blood sugar) and dehydration all have the potential to cause temporary lack of capacity. People may have more capacity at certain times of the day, in certain environments or with the support of certain people which help them feel more relaxed and at ease. Social workers will need to consider the full range of factors to help people make decisions and take control of their own lives and support needs.

Because capacity is a time-specific and decision-specific issue social workers will find that depending on the time of day, the environment the person is in and the context and type of decision needing to be made, people may sometimes have capacity and sometimes not. It is even more important to not make assumptions in these situations and to consult with those who know the person best to decide whether, and if so when, a capacity assessment is best carried out.



Remember: Where fluctuating capacity is an issue a social worker should always ask ‘can the decision be delayed?’ and if it can they should advocate with colleagues for this to happen. **You should** always aim to support the person to make the decision for him or herself wherever possible.

Assessing Capacity: A focus on the two-stage test

In situations where there is reason to doubt an individual’s capacity to make a specific decision at a certain time, the two-stage test set out in sections 2 and 3 of the Act needs to be followed before any intervention is carried out. A best interests decision should only be made in situations where the person has been shown to lack capacity to make the decision him or herself.

Reflective exercise:

Thinking about your own practice and the practice of other professionals that you have observed where you have previously worked with someone who you assessed as lacking capacity:

- *On what evidence did you base your assessment?*
- *How did you involve the individual and other relevant people in making your assessment?*
- *How did you record your assessment?*

Capacity is defined in the Mental Capacity Act 2005 as the ability to **U**nderstand, **W**eight or use and **R**etain the important information and the ability to **C**ommunicate that decision.

- ✓ An individual only needs to fail one of these areas to be deemed as lacking capacity to make that specific decision at the specific time. We will consider each of these areas in detail later in this module.



A short video showing extracts of a capacity assessment is available on social care TV titled 'Ada's assessment' This can be viewed at:

<http://www.scie.org.uk/socialcaretv/video-player.asp?guid=c621ad85-8703-43b6-93e7-8be7fa6f4266>

An impairment or disturbance in the mind or brain

The fact that someone has a condition, illness or other concern that affects their mind or brain is not reason to assume one way or the other that they lack capacity in a given area.

A range of difficulties can impact temporarily on our decision-making abilities, as can longer-term disabilities and difficulties, however this needs to be considered in connection with the ability to make a decision following the functional test and not in isolation.

The link between an individual's impairment/disturbance and the ability to make a decision has also been highlighted in case law, termed as the 'causative nexus' by Lord Justice MacFarlane (2013) who stated in one judgement:

'... If the conclusion reached by the assessor is that the person lacks the ability to make the decision, the assessor must then decide whether this is due to the fact that person [is suffering from an impairment or disturbance of the mind or brain].'

(MacFarlane, L.J. in PC v City of York Council [2013] Para 58)

As a social worker assessing an individual's capacity it may be that the disturbance or impairment is clearly evident or already identified. However, where this is not the case you will need to consider whether views of other colleagues are needed to help you decide firstly whether the person meets this criterion and secondly whether it means they are unable to understand, retain, weigh or communicate a decision as a result.

Learning activity: Impairment or Disturbance of the Mind or Brain

Read the following list and decide which of you would consider being a disturbance or impairment of the mind or brain:

1. Dementia
2. Learning disability
3. Autism
4. Unconsciousness
5. Shock
6. Exhaustion
7. Intoxication
8. Infection



Remember: while this stage of the capacity test is often referred to as the diagnostic element this does not mean that a formal diagnosis of mental disorder, learning disability or dementia is required – a wide range of things can impact on the mind and brain which could result in a temporary or permanent impairment or disturbance that can affect a person's ability to make a decision.

Understanding the Information

When thinking about undertaking your assessment of capacity with an individual it is important to be clear about the specifics of the decision needed and the information the person will need to make an informed decision in this case.

Useful Information: Checklist – Understanding the Information

Consider and identify what information is relevant

- To the nature of the decision.
- To the reason why the decision is needed.
- To the likely effects of deciding one way or another, or making no decision at all.
- ✓ Does the person have general understanding of what the decision is and why they are being asked to make it?
- ✓ Do they understand the consequences of making, or not making, the decision?
- ✓ Are they able to understand the information relevant to the decision?
- ✓ Can they assess the relative importance of the information?
- ✓ Can they use the information as part of the decision-making process?

Recent cases have highlighted the need to make sure that professionals do not set the threshold too high for what a person needs to understand in order to be assessed as having the necessary capacity to make the specific decision. (See following cases for relevant judgements: *Re KK*; *CC v KK* (2012) EWHC 2136 (COP) and *Wandsworth CCG v IA*, and *TA* [2014] EWHC 990 (COP)).

Learning activity: Identifying the Salient Information

Read the following scenarios and identify the information you think each individual would need to be able to make a decision about his future care plan.

Mr K is a 92-year-old man who lives alone. He has recently been admitted to hospital following a fall in which he suffered from a fractured hip. The medical team have declared that Mr K is now medically fit for discharge but are concerned as he is insisting on going home. His mobility is very limited, he requires assistance with personal care and preparing meals and does not remember which medication he needs to take and when.

- What information does Mr K need to understand to be assessed as having capacity to make this decision?

Useful Information: Understanding the Information – Hints and Tips

- Take time to enable the person to take in the information.
- Try to give the most appropriate amount of information (avoid confusion and under-informing).
- Provide info on risks and benefits.
- Explain effects of the decision on the person and on close persons and carers, positive and negative.
- If there is a choice, present the information in a balanced way.
- Consider if the person requires advice from another source.

Retaining the Information

The requirement in this aspect of the assessment is to consider whether someone is able to remember the information they need to make the specific decision for long enough. There is not a set time that applies to this and neither is there a requirement that the person remembers the decision at a later date. Section 3(3) of the Act makes it clear that people who can only retain information for a short period must not be automatically assumed to lack capacity to decide, with the Code of Practice (DCA, 2007) expanding this to consider specifically what is needed for the decision in question and other methods that can be used to help people to retain information, for example notebooks, photographs, videos, voice recordings etc. (see DCA, 2007; para 4.20).

This can make this area difficult to assess as you will need to consider specifically how long the person would need to retain information in order to use it to make the decision. For small

day-to-day decisions this is likely to be a much shorter time than for more complex decisions that may have longer-term or more serious implications.

In some situations, while memory tests can be a useful tool they are not an indicator in relation to overall capacity and may need to be adapted depending on how long a person needs to retain information for each individual decision.

Reflective exercise:

Thinking about your own decision making, how long do you need to retain the relevant information in order to make decisions about:

- *What to have for tea?*
- *Whether to buy a new house?*
- *Whether to get married?*
- *Whether to change jobs?*
- *Where to go on holiday?*

Now reflect on these areas and consider the decisions you make with or on behalf of the service users you support and how long you would need to retain the relevant information in each case.

Weighing or Using the Information

Once the information is identified and provided to the person they need to be able to consider and weigh up the information in order to make a decision.

A number of conditions might impact on a person's ability to weigh up information and you will need to consider how a person's condition is likely to impact upon this element of the capacity assessment.

For example in *Re E (Medical treatment: Anorexia) (2012) EWHC 1639 (COP)* it was determined that someone may be able to understand and retain information but be unable to 'use' it because of conditions such as:

- paranoia
- delusory beliefs
- phobias and morbid fears (e.g. calories in anorexia).

Learning activity: Weighing or Using Information

Read the following scenarios and consider whether you feel each person is able to weigh or use the relevant information to make the specific decision.

- *Fred does not appear to be aware he's in hospital and appears to think he's in his house. He often refers to the surprising numbers of people in his living room when he sees other patients. Can he be aware of the **choices** that face him around his forthcoming discharge?*
- *Katherine has had a number of hospital admissions for infections and falls. The professionals, and her daughter who lives 150 miles away, all believe she is unsafe at home. Katherine tells the social worker that she knows people think she will be better off in care but if it comes to it, she would rather die on the floor at home than go into a residential home.*
- *Ernie is in hospital following surgery after a broken hip but flatly denies ever having had falls at home or having had an operation during his admission. Is he aware of the likely **consequences** of going home without a support package as he insists?*
- *Deborah does not recall having had a diagnosis of diabetes, is upset at dietary restrictions care home staff impose and is hostile to community nurses who visit to give her insulin injections, as she believes she doesn't need them. Could she have capacity to **refuse** this treatment?*

What is supported decision making?

In 2007 the Department of Health published *Independence, Choice and Risk: A Guide to best practice in supported decision-making* (DH, 2007). This guidance promoted the objective of ensuring that individuals were supported to make their own decisions wherever possible where they may have some difficulties in understanding or making choices about an aspect of their life.

Useful information: Independence, Choice and Risk (DH, 2007)

'People have the right to live their lives to the full as long as that doesn't stop others from doing the same.'

- ✓ Help people to have choice and control over their lives.
- ✓ Recognise that making a choice can involve some risk.
- ✓ Respect people's rights and those of their family/carers.
- ✓ Help people understand their responsibilities and the implications of their choices, including any risks.
- ✓ Acknowledge that there will always be some risk, and that trying to remove it altogether can outweigh quality of life.
- ✓ Continue existing arrangements for safeguarding people.

Whether an individual is presumed to have capacity or assessed as lacking capacity in relation to a decision, as professionals we need to ensure that individual wishes, preferences and rights are protected and assumptions about an individual's capability do not prevent them from making decisions for themselves.

Learning activity: Supporting decisions

Read the following example and consider what you would do to support Andy in this scenario.

Andy lives with his family in Cumbria. He has autism and a learning disability. After leaving college, Andy was offered a place at a day centre for adults with learning disabilities, but he knows he can do much more. He wants a job – working with cars if possible. Andy's mum is worried that he won't be able to manage in a 'proper job' and will come to harm or be taken advantage of because of his condition. Andy found a course at college where he could learn about the different aspects of motor sport and now wants to get a part-time job at a local garage.

In March 2014, the House of Lords published their post-legislative scrutiny paper on the Mental Capacity Act 2005. While stating that 'the Act, in the main, continues to be held in high regard... its implementation has not met the expectations that it raised'.

The report explores each of the key principles in depth, and their Lordships make these statements in relation to the principle of supported decision making.

- Irwin Mitchell LLP reported that 'there is less focus on supporting people with making decisions than assessing whether they can make those decisions or not'.
- The Challenging Behaviour Foundation submitted that 'those affected by the Act are not being enabled or supported to make decisions for themselves or in their best interests'.

- Instead, we were told, ‘there is still a tendency to understand the Act as a framework for making decisions for or on behalf of a person rather than encouraging and maximising their participation in the decision making’.
- The Law Society concluded that ‘the focus continues to be on protection rather than enablement, and on best interest decision making as opposed to supported decision making by the impaired person’.
- This was borne out by the Alzheimer’s Society, which reported calls to its helpline about ‘individuals being deemed to lack capacity to make a decision, rather than being supported to make their own decisions as intended by the legislation’.
- The Nuffield Council on Bioethics... advocated a form of supported decision making which relied on making decisions jointly ‘with trusted family members’.
- The Sussex Partnership NHS Foundation Trust suggested that the requirement for supported decision making ‘placed a significant burden on staff’ and that ‘work pressures at times override ethical and legal principles because of a lack of understanding’.
- Cambridgeshire County Council called for ‘more emphasis [to] be given to the second principle’ but it conceded that this raised issues of resources, both in terms of time, and also staff training.
- The impact of reduced resources on supported decision making was addressed more widely by Mind: ‘To assess, engage and empower a person who may lack capacity can be resource intensive. It may require help from speech therapists or occupational therapists or for more time to be devoted to that person by the care staff or clinical team supporting them. There is a risk that in a time of austerity when resources are scarce there will be a temptation to cut corners and to fail to properly give effect to the requirements of the Act.’

They suggested placing considerably greater emphasis on supported decision making, to the point that decision making based on objective best interests rather than the views of the person becomes a last resort, limited to those individuals who cannot communicate their wishes and feelings at all.

Supported decision making and assessing capacity

In the previous section we explored the concept of mental capacity and the importance of the presumption of capacity, and considered some of the criticisms that were made by the House of Lords in relation to how professionals were using the Mental Capacity Act. The report also highlighted that professionals are too frequently using the Act as a means of making decisions on behalf of others, rather than assisting them to make their own decisions.

There is a danger that social workers and other professionals shortcut the process of supported decision making and jump direct to the assessment of capacity, which is likely to lead to more people being assessed as lacking capacity, due to insufficient attention being given to supporting them to make the decision. A request from another professional or a manager to assess a person’s capacity to make a particular decision can further aggravate this.

The Law Commission proposals (2015) on the reforms needed for the MCA and DoLS procedures includes a significant focus on this area and their proposed scheme includes comprehensive proposals on what is termed ‘supportive care’ as a means of preventing deprivations of liberty or other restrictions and providing a preventative focus within the operation of the safeguards provided in the MCA.

Reflective exercise:

Consider when you have been asked to undertake an assessment of a person’s capacity to make a decision.

Try to reframe this request, by making the task a piece of work to **support the person to make the decision in question**, rather than an assessment of capacity.

May this have the effect of subtly changing the agenda of the task from simply making a decision on the person’s capacity to make the decision, to actively working with them to assist them to make that decision themselves?

The process of working with the person to support their decision making will at the same time inform a capacity assessment, as the social worker will be determining whether the person is able to understand the information being given, retain it long enough to make the decision; and to use and weigh the information in order to make the decision. If it becomes evident to the social worker that the person is unable to do one or more of these activities in the process of supporting their decision making, then it will become apparent that the person lacks capacity to make the decision, notwithstanding the required support being provided.

Useful information:

Checklist: Assisting people to make a decision for themselves

- ✓ Communication – are you using tools and techniques to maximise the individual’s understanding, including any relevant communication aids?
- ✓ Location – is the place where you are communicating with the individual and/or assessing their capacity suitable? Is it relaxed? Noise levels? Privacy?
- ✓ Timing – are you trying to support the individual at the best time of day for them? Ask the person themselves and those that know them best.
- ✓ Support from other people – do you need others who are able to put the individual at ease? Do you need input from other professionals to help you communicate effectively? Is an interpreter needed?
- ✓ Delaying the decision – can the decision be delayed if the person is unable to make the decision themselves?

Maximising Communication

One of the key criticisms of the House of Lords report (HoL, 2014) was that professionals needed to ensure they communicated all the various options to an individual and not start

with what Justice Baker referred to as a 'blank canvas'. You will need to ensure that the individual is provided with the necessary information to support them in the decisions they need to make. It may be you need to adjust the format of the information being provided or otherwise make adjustments (for example in terms of timing, location or drawing on others) to support the decision-making processes.

Reflective exercise:

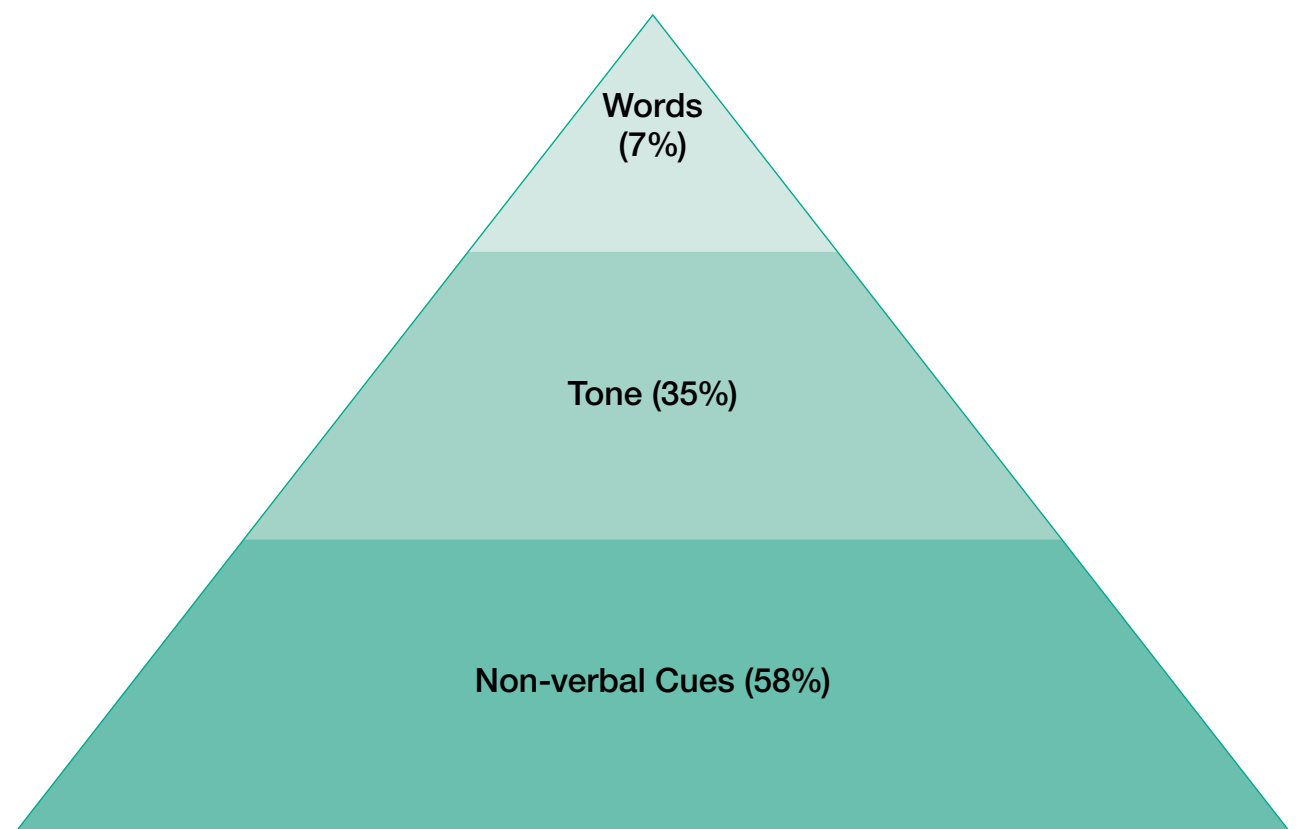
Think about two examples from your practice:

1. Where you feel you had a successful outcome with a service user or carer.
2. Where the outcome was not as successful.

In each case consider the communication skills you used with the individual – what impact (both positive and negative) did this have?

Verbal communication is only a small part of the way we communicate with people. Communication theory suggests that in people with no development or other difficulties words are a small proportion of our communications, and tone and non-verbal language are very important in terms of how we interact with the world and with other people.

As a social worker assisting someone to make a decision, you will need to consider how you communicate with individuals who may not be able to understand verbal cues in the same way as you or I do and as a result how you support them to make a decision.



In some cases you may be able to access support from other professionals, for example speech and language therapist colleagues, however this is likely to be the minority of cases and you will need to think about how you ensure that the person has access to the information they need and how you can support them to weigh and retain that information.

Tools such as pictures, diaries, stories, written prompts, visual prompts (i.e. visiting a service before using it etc.) are all necessary considerations and you may need to take longer with this task to make sure you have maximised the individual's capability to make, or take part in, any given decision before you conclude they lack capacity.

Learning activity: Maximising Communication

Read the following example and consider what you would do to support KK in this scenario.

KK is an 82-year-old woman who has had a disability since her childhood (left-sided paralysis from a diphtheria inoculation at the age of 3). Her husband died after 34 years of marriage when she was in her early 70s and she moved into a bungalow.

She developed vascular dementia and Parkinson's disease and, together with her hemiplegia, became increasingly physically disabled. Concerns about her vulnerability increased from 2009 (aged 80) and KK had a number of short admissions to hospital.

She was assessed as lacking capacity for her care and residence while in hospital in July 2010 following a fall, and admitted to a care home, but she improved and was assessed as regaining capacity in October of that year and discharged home. She was further assessed as lacking capacity (for the same decisions) in July 2011, readmitted to a care home and a DoLS standard authorisation was sought and granted in August 2011.

In the case detailed above, Justice Baker, the presiding judge, criticised the assessing psychiatrist who stated that he starts his capacity assessments with a 'blank canvas', not setting out the care planning options, but asking people to give him their 'ideal opinion' as a means of obtaining material to assess their capacity. Justice Baker went on to state the following:

'... it is inappropriate to start with a "blank canvas". The person under evaluation must be presented with detailed options so that their capacity to weigh up those options can be fairly assessed. ... The statute requires that, before a person can be treated as lacking capacity to make a decision, it must be shown that all practicable steps have been taken to help her to do so. As the Code of Practice makes clear, each person whose capacity is under scrutiny must be given "relevant information" including "what the likely consequences of a decision would be (the possible effects of deciding one way or another)". (para 68)



The House of Lords report (2014), including the complete set of recommendations, can be downloaded from:

<http://www.publications.parliament.uk/pa/ld201314/ldselect/ldmentalcap/139/139.pdf>

Communication skills are a core social work capability area; much of our practice is focused on the relationships we develop with people to support them to maintain independence and self-determination and as such this principle area is one which should be embedded in social work practitioners' consciousness.

Even in cases where an individual is assessed as lacking capacity their involvement should be sought and the views and wishes of the individual taken into account.

Useful information: Case Example – Supported Decision Making

Alan is a 41-year-old man with a moderate learning disability. He had been sharing a home with a man called Kieron, in accommodation provided by the local authority. Alan received constant supervision within his placement and in the community. Alan had a vigorous sex drive, which led to sexual relations with both men and women. He had developed a sexual relationship with Kieron that involved penetrative anal sex.

Two events prompted the local authority to make an application to the Court of Protection:

1. A young boy in a dentist's waiting area observed a man touching his groin and licking his lips, and was then asked by the man for his name. The dentist's diary showed that Alan was due for an appointment at that time.
2. Two days before, two girls aged 9 and 10 stated that when travelling on a bus a man had commented upon their physical appearance, touched their upper legs and then attempted to look up their skirts. The police were notified.

Approximately three weeks later, the same two girls were travelling on the bus once again, as was Alan. The girls notified the bus driver who also notified the police. Alan was then taken to the police station and questioned. However, the police decided that no further action should be taken against him.

The local authority sought a declaration that Alan lacked capacity to consent to sexual relations and an order authorising a restriction of contact between Alan and Kieron (and between Alan and another person) so as to prevent further sexual relations taking place.

The details of the test of capacity for sexual relations are complex and is not the main purpose of this document, but the importance of ensuring that all reasonable steps have been taken to help a person make a decision is covered in the judgement.

The judge concluded that at the time of the hearing, Alan did not have capacity to consent to and engage in sexual relations. However, he questioned whether further steps of a sex-educative nature should be taken to bring Alan up to the requisite level of capacity so the restrictions on his sexual activity could be lifted. The psychiatrist who provided expert evidence argued that such a project would be a bad idea. He said that if such a project were initiated Alan may well become confused, with raised levels of anxiety. This may make him very anxious with a consequential deterioration in his (presently very good and compliant) behaviour. Challenging behaviour may arise, which may put his current placement in jeopardy. Therefore he advised against this proposal.

The judge went on to state that: *'[the psychiatrist's] evidence is wholly valid when viewed through the prism of best interests. Yet I believe that an issue such as this must surely be subject to a threshold akin to that of significant harm, as is applicable to children when the state seeks to intervene under... the Children Act 1989. This must be implicit in s1(3) MCA. I am not satisfied that sufficient practical steps have yet been taken to see if Alan can have sex, with the result that the present regime of deprivation of liberty can be lifted.'* (para 51).

The judge went on to order that the local authority provide Alan with sex education in the hope that he thereby gains that capacity. An order was made for the case to be returned to the court in nine months for review in order to see what progress the education is making, with a view to making final declarations at that point.

What is an unwise decision?

Unwise decision making is one of the areas that are often most challenging for professionals in practice. While social workers have a focus on self-determination and empowerment of individuals the need to advocate for an individual's right to make a bad choice, knowing that the choice may well result in poor outcomes for that person, does not always sit comfortably with the underpinning ethos of supporting individuals who may present with a range of problems and vulnerabilities.

Useful Information: The right to make unwise decisions

- ✓ People have the right to make decisions that others might regard as unwise or eccentric.
- ✓ You cannot treat someone as lacking capacity for this reason.
- ✓ Everyone has their own values, beliefs and preferences which may not be the same as those of other people.

The House of Lords recognised that this was an area that was creating a significant challenge in practice in their post-legislative scrutiny report (HoL, 2014) stating that:

'...the balance between empowerment and protection emerged as a key challenge to the implementation of the empowering ethos of the Act, and this seems most clear in relation to unwise decision making. The right to make an unwise decision runs counter to the prevailing cultures in health and social care, which presents barriers to implementation.' (para.84)

Thinking about how you work with this principle of the Mental Capacity Act 2005 is an important area of critical analysis and reflection. Your own values and beliefs will have a direct impact on your responses to individuals and the decisions that they are making. The so-called 'blame' culture that exists towards social workers can add to the anxiety that unwise decision making among service users can create and you will need to use supervision and peer support as well as continue to reflect in relation to decisions which you find difficult or which conflict with your organisation or personal values.

Learning activity: Unwise Decisions?

Read the following example and consider whether you believe the decisions in each case are unwise or not – explain your arguments, including identifying the values underpinning your view where possible

- Steven is a 42-year-old male, diagnosed with type 2 diabetes and hypertension; he has a range of symptoms including regular urinary tract infections, gout and dizziness. Simon is overweight, drinks several pints of beer each night and smokes 20+ cigarettes a day; he is prescribed a range of medications to control his symptoms, however he takes these irregularly as he experiences a range of side effects including insomnia and erectile dysfunction. Steven's symptoms have fluctuated over the past two years; he has been admitted to general hospital on a number of occasions due to unstable blood sugar levels and once due to experiencing a blackout in the street when out with his wife. Steven could improve his symptoms with medication compliance, exercise and diet but has so far been unwilling to make the lifestyle changes needed to maintain these things.
- Simon is a 42-year-old male; he is diagnosed with paranoid schizophrenia and has a range of symptoms including depression, thought disorder, deliberate self-harm, auditory hallucination and delusional beliefs relating to others trying to harm him. During phases of active illness he has been known to barricade himself in his flat and disconnect all electrical appliances. He has no history of violence or aggression towards others and his self-harm consists of shallow cutting to his forearms and thighs, he has been admitted to hospital on one occasion during the last five years and this was under section 2 of the Mental Health Act 1983. He is prescribed several medications but complains of several side effects including constipation, sedation and significant weight gain. Simon is very distressed about the weight gain he has experienced; as a result he does not want to take his prescribed medication so when his mental health is stable he is able to enjoy a better quality of life.

The Impact of Personal and Professional Values

As highlighted by the House of Lords report (HoL, 2014) the ethos of our professional cultures, and hence our own values and the values of the social work profession are key factors to consider within this principle, As one experienced social worker and mental capacity practitioner states when training others:

'We are very social beings and large parts of our brains are hard-wired to attribute social meaning to communication and behaviour. This tendency to impose meaning on social situations can hamper the dispassionate assessment of someone else's cognitive ability, as your brain is trying very hard to "make sense" of an interaction in social terms – can't answer or won't answer? Aloof or unable to manage the demands of a conversation? Friendly and accommodating but did P grasp the situation they face? Awareness of your own deeply ingrained expectations about social interaction may assist you in determining whether the person you are talking to does indeed have an effective understanding of an issue they may have to take a decision about.'
(Laidlaw, 2013)

Reflecting on the impact of your own values and beliefs, and those of the individuals with whom you are working, is important for social work practice and particularly relevant to the effective application of this principle.

Each of us sees the world differently and social workers need to ensure they take account of these differences and the impact they can have within their practice.

Reflective exercise:

- *How do you determine what is wise or not? What is risky or not?*
- *Now consider your emotional responses to some of the behaviours and decisions you would consider to be unwise; how do you respond to these in practice with individuals who make these choices for themselves?*



Remember! *You will need appropriate professional supervision and support from your organisation/peers to maintain a critically reflective approach to working with what may be perceived as an unwise decision.*

Unwise decision or a lack of capacity?

The Code of Practice (DCA, 2007) for the Mental Capacity Act 2005 highlights that in some circumstances repeated unwise decisions may suggest that a capacity assessment is required in relation to that particular decision. This does not overrule the individual's right to make an unwise decision but rather there are some decisions that should raise concerns in

professionals. For example, a person repeatedly puts themselves at significant risk of harm or makes a decision that is out of character (DCA, 2007; Para. 211).

In *YLA v PM* [2013] Justice Parker highlighted that there was a clear difference between unwise decisions and decisions based on a lack of understanding and part of your practice may include considering and analysing situations, and making decisions about whether or not a capacity assessment is required, based on what you know about the individual and what they are telling you about the choices they are making, along with consultation with others who know the person and other involved professionals. Justice Baker highlighted this in *CC v KK* [2012] who recognised that ‘... *different individuals give different weight to different factors*’ (Para. 65).

What this means is that you will need to consider the priority that individuals put on different actions and outcomes. It may be that the person themselves understands the risk and is happy to take it (for example, think about those who smoke, drink alcohol or take part in dangerous sports) or it may be that the person does not recognise that there may be risks or consequences to their decisions. Part of the social worker’s responsibility in either case will be to ensure that the person has the appropriate information they need in order to make the decision being considered.

Learning Activity:

Read the following scenarios and identify which ones may make you consider whether capacity is a factor in the decisions being made. Consider your emotional response to each of the scenarios described – how does this impact on your professional practice?

- Bryn likes to pick flowers and regularly goes for walks in his local area to pick flowers. He picks a colour each day and tries to pick just flowers of that colour. He has been found on two occasions this week by the police walking down the hard shoulder of busy main roads, when asked why he says ‘because that’s where the blue ones are’.
- Sally is diagnosed with a personality disorder; she regularly self-harms and drinks alcohol to the point of intoxication. Sally has been threatened with eviction from her flat as she has been having people round and causing public disturbances. She says that she doesn’t care because ‘they won’t do it’.
- Graham is 82 and lives in a residential care home. When drunk he becomes aggressive and the police have been called to the home several times as a result. The care home has given him notice to leave and he is now being assessed for an alternative placement. There is a unit close by that would be able to meet his needs but to enter the facility Graham has to stop drinking. He says he has no intention of doing so.

Unwise Decisions and Safeguarding

Issues such as safeguarding and the professional (and the public's) perception of the social worker's 'duty of care' can make sitting back while the individual engages in risky behaviour very difficult. Even in situations where the individual has the capacity to make unwise decisions this does not necessarily mean that your responsibilities end, but rather you may need to consider a different framework than that provided by the Mental Capacity Act 2005.



Skills for Care have published a range of training materials to support social care and social work staff to implement the new duties under the Care Act 2014, including materials that consider the changes to safeguarding. These can be accessed here:

<http://www.skillsforcare.org.uk/Standards/Care-Act/Learning-and-development/Learning-and-development.aspx>

It may be the case that self-neglect has been viewed as an unwise decision in the past where it didn't meet the threshold for the Mental Health Act 1983 or other legislation, rather than necessarily as a result of a capacity issue. The implementation of the Care Act 2014 in April 2015 will introduce the category of self-harm to the definitions of what constitutes a safeguarding concern. Chapter 14 of the statutory guidance to accompany the Care Act (DH, 2014) states that self-neglect:

'... covers a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding'. (DH, 2014; p.234)

How each local authority responds to this new responsibility may have an impact on how social workers respond to unwise decisions in this area, and while you will need to ensure you respect an individual's right to make the choice, some protective measures may still be required. You will need to ensure you are familiar with this area, and have accessed the relevant training and support to understand how your organisation expects you to respond in relation to areas such as this.

It is important to remember that the onus is on the social worker to demonstrate that the person lacks capacity and provide evidence to support their conclusions; not on the person to demonstrate they have capacity. In the context of principle 1 of the Act (see Module 1: Presumption of Capacity) the starting point should always be an assumption that the person has the capacity to make decisions for themselves, regardless of whether the decision is considered to be unwise by others. However this does not mean that social workers do not have responsibility where an individual may in fact lack capacity or does not have the information they need to make the decision in the first place.

Where there is a need to undertake a capacity assessment practitioners need to consider each element of the two-stage test and ensure that they involve the person, consult others – informal supporters and professionals – where appropriate and provide evidence to support their judgements.

Reflective exercise:

Refer back to the reflective exercise at the start of this module where we asked you to describe how you perceived and responded to decisions you felt were unwise. After working through this module consider the following questions:

- What are your key learning points from this module?
- Have your views/attitudes changed as a result of the information and activities in this module?
- How will this learning impact on your social work practice?

What is best interests decision-making?

The Act sets out a statutory checklist that decision makers must follow when making best interests determinations (MCA s4). This means that decisions that professionals make take into account the wide range of factors that influence how a person decides.

Useful information: Best Interest Checklist Summary

- Do not make decisions based on the person's age, appearance or any other factor which may lead to unjustified assumptions about their best interests.
- Consider all circumstances relevant to this particular person.
- Is the person likely to regain capacity to make the decision?
- Encourage and facilitate the person's participation in the decision-making process.
- If the decision relates to life-sustaining treatment, the decision must not be motivated by a desire to bring about the person's death.
- Consider, as far as reasonably possible, the person's past and present wishes and feelings, beliefs and values.
- Consult with and take into consideration the views of a range of other people, including:
 - anyone named by the person to consult;
 - anyone caring for the person or interested in their welfare; and
 - any donee of a LPA or any deputy appointed by the court.

What Best Interest Decisions are not

- Are **not** simply an assertion of your own opinion or recommendation, personal or professional.
- Are **not** professional 'power language' to overawe the person or their supporters or close down discussion.

- **Cannot** be said to have been taken without full consultation with supporters having taken place.
- Are **not** exempt from scrutiny – DoLS procedures, complaints, ombudsman, at judicial review, in the Court of Protection.

If the action being considered does not or cannot conform to the template of the Best Interest checklist, then consideration needs to be given to other powers and procedures.

House of Lords view on Best Interest Decision Making

In March 2014, the House of Lords published their post-legislative scrutiny paper on the Mental Capacity Act 2005. While stating that ‘the Act, in the main, continues to be held in high regard... its implementation has not met the expectations that it raised’. The report explores each of the key principles in greater depth, and their Lordships make these statements in relation to the principle of best interests decision making.

The British Institute of Learning Disabilities reported that, ‘The centrality of the person’s wishes, beliefs, values and history within a best interest view is very good. However, all too often “best interests” is interpreted in a medical/paternalistic sense which is wholly at odds with that set out in the Act’.

Dr Claud Regnard put it more strongly: ‘the term “best interests” is probably the most abused and misunderstood phrase in health and social care. It has too often been the vehicle for poor decision making as described in many of the cases in Mencap’s *Death by Indifference* reports’.

Moira Fraser of the Carers Trust reported that families had the impression that ‘professionals pick and choose when to involve them’. Furthermore, families who disagreed with the decision being made found they were excluded on the grounds that ‘they are not acting in the best interests of the person whom they care for’.

Mencap reported that families of adults with learning disabilities were not being consulted by medical staff as they should be and as a result many ‘think that the only way that they can assist in the decision making of an adult with a learning disability is by becoming a welfare deputy’.

According to the Carers Trust and Carers UK, one of the difficulties in challenging the misuse of the Act was the general lack of awareness of its provisions, particularly the best interests decision-making process, among family members and carers.

Evidence was provided that families were surprised to discover that they were not the decision maker on behalf of their relative: ‘many family members still feel they have an inherent right to make decisions on someone else’s behalf; this appears to be particularly evident in families of a person with a degree of learning disability’.

Hft, the charity supporting people with learning disabilities and their carers, said that ‘Parents (or other family members) need to know that, by law, they are no longer decision maker by default as is often the case when your son/daughter, brother/sister is a child’.

Oi Mei Li, Director of the National Family Carer Network, referred to this change as ‘a complete culture shock’ which had ‘an enormous emotional impact on family carers’. Professor Celia Kitinger and Professor Jenny Kitinger pointed out that ‘even academic audiences are surprised that next of kin cannot make decisions for another adult’.

Evidence also revealed confusion over who was responsible for making a decision in a best-interests process. North Yorkshire County Council said that greater clarity was needed, and that ‘the examples given in the code do not reflect the complexity of circumstances that can surround many decisions to be made’.

A joint submission from the London Borough of Hammersmith & Fulham, the Royal Borough of Kensington & Chelsea and the City of Westminster concurred, and suggested that ongoing training and support was needed ‘to ensure that it is clear who the decision maker is’. Toby Williamson said that, particularly in complex decisions involving multidisciplinary teams, ‘staff were struggling to understand who a decision maker is and what is the exact decision that was being made’.

Evidence from Sense agreed: ‘in best interests meetings involving more than one agency... it can be extremely difficult to determine who the decision maker should be’. There were also concerns that a decision maker could assume too much power, and sometimes on the basis of questionable legal authority. Sheffield Safeguarding Adults Board pointed out that ‘once a person has been deemed to lack capacity to make a decision they become vulnerable to the opinion of the decision maker and when those decisions are not reflective of their best interests it often leaves them powerless to challenge’.

This was echoed by other witnesses who expressed concern over the use of the ‘general defence’ – the term often used to describe sections 5 and 6 of the Act (Acts in connection with care or treatment and Section 5 Acts: limitations) – which provides protection from liability for carers and others to carry out acts in relation to a person who lacks capacity.

In the social work context much evidence focused on the misuse of the best interests principle in order to justify decisions taken by local authorities about an individual’s care, without carrying out the necessary consultations, and often against the wishes of P and P’s carers. Families believed what they were told: ‘The social worker said they are using Section 4 of the Mental Capacity Act to do this’.

The Mental Health Foundation argued that there was a risk of the best interests principle becoming ‘a tool to justify decisions to safeguard people’.

The case of Steven Neary further illustrates this: ‘In our case, a decision was made from very early on that Steven could not return home and instead [should] be sent to a residential establishment. Neither Steven, myself or any other independent person were involved in that decision. Having made that decision, the [local authority] then launched into proving that Steven did not have the capacity to decide where he wanted to live’.



A short video made by Mr Mark Neary talking about his experience while Steven was under the care of LB Hillingdon is available on youtube. It can be accessed here:

<https://www.youtube.com/watch?v=TpOkpWQCMeY>

The overlapping of best interests decisions with capacity assessments has been noted in research carried out by the Mental Health Foundation, who referred to it as the ‘concertina effect’ – a process whereby the steps set out in the principles of the Act are rolled into one, effectively negating the empowering ethos and being led by the outcome decided on by professionals.

Balance Sheets

When considering a person’s best interests, the Courts have frequently adopted a ‘Balance Sheet Approach’ (SCIE 2011) as an assessment tool to weigh the benefits and burdens of each available option. For example:

David remaining in Poplar Court		David returning home with a package of support	
<u>Benefits</u>	<u>Burdens/Risks</u>	<u>Benefits</u>	<u>Burdens/Risks</u>

Past Expressed Wishes

The Court of Protection judgement in Sykes (2014) indicates that a person’s past expressed beliefs/wishes and values are the ‘nub of the matter’ when assessing their best interests (39 Essex Street 24/02/2014). In Aintree University Hospitals v David James (2013), the court ruled the need for a holistic assessment of best interests which gives equal weight to social and familial factors.

Resolving conflicts/Article 8 Human Rights Act

The MCA Code (5.68) states that ultimately, if following advocacy and mediation, it is not possible to resolve a conflict regarding what is in a person’s best interests, then it may be necessary to apply to the court for a decision. This is especially the case where there are disputes between professional and family members regarding where a person who lacks

capacity should reside. In the cases of *G v E* (2010), *LB Hillingdon v Steven Neary* (2011), *Somerset v MK* (2014) and *Milton Keynes v RR* (2014), the courts found that local authorities had breached the Article 8 Right to Private and Family Life by moving vulnerable people despite the opposition of their families. These judgements clearly indicate that where there are disputes local authorities should not exceed their statutory powers and that the onus is on the public authority to make a timely application to the court. They also indicate that the burden of proof is on the public authority to demonstrate that they can provide better care than the family.

Best Interest Decision Making: Case Examples

It is not always clear what is in someone's best interests and professionals, informal supporters and the person themselves may all have different views about what best interests actually are.

As a social worker practising in this area it is likely that you will be involved in best interest meetings and decisions with other colleagues. In these situations you will need to ensure that you follow the best interest checklist set out in s4 of the Act and Chapter 5 of the Code of Practice (DCA, 2007): this will ensure that you are able to work within the appropriate framework and apply decision making as intended by the Act. The following examples are taken from a range of court cases where best interests was being explored and are intended to provide you with an overview of how this principle is being applied in practice and in court.

Useful Information: Case examples

Mrs Jones is a 66-year-old woman who lives alone and is financially dependent on DWP benefits. She has a 29-year-old son, Martin, with whom she has a complex and difficult relationship, dating back to his childhood. He has a drug and alcohol habit and visits his mother on the days she receives her benefits. She provides him with money, resulting in her being short of money towards the end of her benefits period. She often cannot afford to buy food for the last few days before her benefit is due, and cannot afford to charge her electricity key, resulting in her being cold and without lights for a day or two.

Mrs Jones has a district nurse who visits her for her long-term health problems and also a social worker; both of whom believe that this is financial abuse and have been advising her to stop giving her son her benefit money and to use it for her own needs. She has always refused, stating that 'blood is thicker than water' and blaming herself for his difficulties. Martin would not visit her if she did not give him some money and she says that she would be heartbroken if she was not able to see him regularly.

A safeguarding alert was raised some time ago, but Mrs Jones is cognitively intact and has the mental capacity to make decisions regarding her financial affairs. It is felt that this is an unwise decision that she is making and as there is no criminal activity, no one can act in relation to her decisions.

Mrs Jones suffers a stroke and is admitted to hospital. She recovers physically and within a few weeks is able to return home. Her recovery has gone well and she is able to manage most of her daily activities, but her mental abilities have been affected and she is no longer able to manage her financial affairs. The local authority take control of her finances as she has no other family apart from Martin, who it is considered is not appropriate to be her DWP appointee.

Mrs Jones still states that she wants to give her son money, and is fearful that if she is unable to then he will stop visiting her. She has said in that case her life 'won't be worth living'.

- ✓ How should the local authority approach the management of Mrs Jones' financial affairs, in the light of her past and present wishes and feelings to give her son significant amounts of her benefits money, such that she has been putting her personal welfare and health at risk?

In **ITW v Z and M**, the judge suggested the stronger and more consistent the person's views, the greater the weight in principle should be given to those views. Mrs Jones is also relatively able in much of her daily activities and could be considered relatively close to the borderline of capacity, and therefore once more, her own wishes and feelings should in principle be given great weight.

However, in **Re P**, the judge stated that a consciously unwise decision will rarely, if ever, be made in the patient's best interests.

It would be within the local authority's power to ensure that Martin no longer receives any of Mrs Jones' money, if it was all kept from her and administered by the social care team. However the evidence is that Martin would no longer visit and this would have a severe impact on Mrs Jones' emotional welfare. She would be safer, in that she would always have enough money for food and power, and maybe some left over for additional items.

But in **Re MM**, the judge commented 'what good is it making someone safer if it merely makes them miserable?'

So an option is to ensure Mrs Jones has sufficient money for her food and power throughout her benefit period, but provide her with some cash for her own use, in the knowledge that she will be giving it to her son when he visits. It could be argued in this circumstance that the local authority is colluding with financial abuse, or on the other hand it could be argued that it is balancing Mrs Jones' physical welfare with her emotional wellbeing.

Re MM (an adult) [2007] EWHC 2003 (Fam)

MM was a 41-year-old woman with paranoid schizophrenia characterised by a variety of hallucinations, with a history of rapid relapse at times of stress. She also had a moderate learning disability with recorded IQ of 56, non-existent verbal recall and was functionally illiterate. She experienced a chaotic and abusive childhood and was taken into care at the age of 13.

At the time of the judgement, she had been in a 15-year relationship with a man named as KM. They had met in a homeless hostel and KM had in the past received a diagnosis of psychopathic personality disorder and alcohol misuse. KM had been physically abusive to MM and it was alleged that he had financially abused her too.

KM had encouraged MM to leave her home, follow him to various addresses and to disengage with psychiatric services. As a result, MM had experienced relapses in her mental health and had slept rough for some periods of time.

The local authority applied to the court to declare that MM lacked capacity to decide on her residence, or with whom she should associate; that she should remain at the supported accommodation in which she was living, and that she should not have unsupervised contact with KM. Their initial request was for ½ hour supervised contact per month.

It was established that MM lacked capacity for the relevant decisions (though had capacity to consent to sexual contact), therefore best interests decisions needed to be made in relation to her residence and contact with KM.

Notwithstanding the sometimes abusive nature of the relationship and the power imbalance between MM and KM, MM's subjective experience was that she looked forward to seeing KM, her appearance improved and she presented as happy.

The judge agreed that it was in MM's best interests to remain living in the supported accommodation, but his comments about contact (and the balance between protection from physical harm and emotional wellbeing) were extremely significant.

'The fact is that all life involves risk, and the young, the elderly and the vulnerable, are exposed to additional risks and to risks they are less well equipped than others to cope with. ***But just as wise parents resist the temptation to keep their children metaphorically wrapped up in cotton wool, so too we must avoid the temptation always to put the physical health and safety of the elderly and the vulnerable before everything else.*** Often it will be appropriate to do so, but not always. Physical health and safety can sometimes be bought at too high a price in happiness and emotional welfare. The emphasis must be on sensible risk appraisal, not striving to avoid all risk, whatever the price, but instead seeking a proper balance and being willing to tolerate manageable or acceptable risks as the price appropriately to be paid in order to achieve some other good – in particular to achieve the vital good of the elderly or vulnerable person's happiness. ***What good is it making someone safer if it merely makes them miserable?***' (para 119)

As a result, the judge left it with the local authority to make such arrangements which would allow MM to continue to have a sexual relationship with KM, as the proposed restrictions on contact would have been a disproportionate infringement of MM's Article 8 rights to private and family life.

'The local authority is by its own acts creating a situation where, if a breach of Article 8 is to be avoided, the local authority must take certain positive steps – specifically, steps to enable MM to continue, in an appropriate and dignified way, her sexual relationship with KM.' (para 162)

ITW v Z and M [2009] EWHC 2525 (Fam)

This case concerns an application by a court-appointed deputy (ITW) to execute a statutory will for M, who lacked testamentary capacity.

M was a childless widow who lived with Z and his family from 2004 until her placement in a care home (authorised by the court) in 2008. In 2004, M executed a will and an Enduring Power of Attorney, both in favour of Z. During the 18 months between July 2004 and January 2006, M transferred nearly all of her savings, a considerable sum of money, to Z. The judge (Munby J) in 2008 was highly critical of Z, both in his concerns for M's welfare and his management of her money.

The application in relation to the statutory will needed to take into account M's wishes and feelings as part of the best interests decision making. Munby J made the following observations.

First, P's wishes and feelings will always be a significant factor to which the court must pay close regard.

Secondly, the weight to be attached to P's wishes and feelings will always be case-specific and fact-specific. In some cases, in some situations, they may carry much, even, on occasions, preponderant, weight. In other cases, in other situations, and even where the circumstances may have some superficial similarity, they may carry very little weight.

Thirdly, in considering the weight and importance to be attached to P's wishes and feelings the court must of course, and as required by section 4(2) of the 2005 Act, have regard to all the relevant circumstances. In this context the relevant circumstances will include, though I emphasise that they are by no means limited to, such matters as:

- a. ***the degree of P's incapacity, for the nearer to the borderline the more weight must in principle be attached to P's wishes and feelings;***
- b. the strength and consistency of the views being expressed by P;
- c. the possible impact on P of knowledge that her wishes and feelings are not being given effect to;
- d. the extent to which P's wishes and feelings are, or are not, rational, sensible, responsible and pragmatically capable of sensible implementation in the particular circumstances; and
- e. crucially, the extent to which P's wishes and feelings, if given effect to, can properly be accommodated within the court's overall assessment of what is in her best interests. (para 35)

Aintree University Hospital v James [2013] UKSC 67

This case before the Supreme Court concerned David James, who was 68 years old and admitted to hospital with multiple health conditions. He deteriorated, was moved to the critical care unit and placed on a ventilator. When it reached the court he was extremely unwell and in a minimally conscious state.

It was the view of the medical professionals that particular ongoing invasive treatments should not be given in the event of Mr James' clinical deterioration. Mr James' family took a different view and believed that although he would never regain his previous quality of life, the patient would want to continue to fight, as he had done when he was being treated for cancer.

The Court of Protection found with the family but the Court of Appeal agreed with the trust and granted the declaration requested. Mr James died on 31 December 2012. However, due to the importance of the issues, leave was granted to appeal to the Supreme Court.

Issues regarding the power of the court to make declarations regarding medical treatment are not relevant in this context, but the comments on the importance of a person's wishes and feelings are highly relevant to all best interests decisions.

The Supreme Court rejected the proposition that the test of a person's wishes and feelings is an objective one, what the reasonable person would think.

'The purpose of the best interests test is to consider matters from the patient's point of view. That is not to say that his wishes must prevail, any more than those of a fully capable patient must prevail. We cannot always have what we want. Nor will it always be possible to ascertain what an incapable patient's wishes are. Even if it is possible to determine what his views were in the past, they might well have changed in the light of the stresses and strains of his current predicament. In this case, the highest it could be put was, as counsel had agreed, that "It was likely that Mr James would want treatment up to the point where it became hopeless". But ***insofar as it is possible to ascertain the patient's wishes and feelings, his beliefs and values or the things which were important to him, it is those which should be taken into account because they are a component in making the choice which is right for him as an individual human being.***' (para 45)

Re M [2013] EWHC 3456 (COP)

M was a 67-year-old woman placed in a care home under a DoLS standard authorisation. She had been living there for a little over a year, previously living in her own home of 30 years, sharing it much of the time (but not permanently) with her long-term partner who had his own home. M had type 1 diabetes since adolescence, had lost nearly all her sight and had a stroke in 2009 along with other health conditions. Following her stroke she became more inflexible in the support she would accept, insisting on her own assessment of her diabetic management.

During 2011, M had five acute admissions to hospital due to diabetic ketoacidosis (a life-threatening condition). After breaking her hip in a care home during one admission from hospital, by spring 2012 she was bedbound, incontinent and confused, and was admitted to the current care home in June 2012.

M consistently said she wanted to go home, threatening to take her own life if this was not allowed to happen. Her condition improved in the care home but her co-operation with care and treatment remained inconsistent. Professionals continued to believe she would be safer in the care home than at home.

Concerns were explicitly raised that further diabetic crises at home could be fatal. It was established that M did not have capacity to make the decision in question, so the judge (Peter Jackson J) made a best interests decision

‘In the end, if M remains confined in a home she is entitled to ask “What for?” The only answer that could be provided at the moment is “To keep you alive as long as possible”. In my view that is not a sufficient answer. The right to life and the state’s obligation to protect it is not absolute and the court must surely have regard to the person’s own assessment of her quality of life. In M’s case there is little to be said for a solution that attempts, without any guarantee of success, to preserve for her a daily life without meaning or happiness and which she, with some justification, regards as insupportable.’ (para 38)

Re P [2009] EWHC 163 (Ch)

This is a case involving the decision whether to make a will on behalf of an incapacitated person. P lacked testamentary capacity and his niece applied to the Court to make a will on her uncle’s behalf.

Although a person’s wishes and feelings need to be fully taken into account, whether expressed in the past or now, they will not necessarily be the deciding factor in working out the person’s best interests.

‘Although the fact that P makes an unwise decision does not on its own give rise to any inference of incapacity, once the decision making power shifts to a third party (whether carer, deputy or the court) I cannot see that it would be a proper exercise for a third party decision maker consciously to make an unwise decision merely because P would have done so. ***A consciously unwise decision will rarely if ever be made in P’s best interests.***’ (para 42)

Westminster City Council v Manuela Sykes (COP 1238388T)

Manuela Sykes was an 89-year-old woman with dementia, placed in a nursing home under a DoLS standard authorisation. She had lived in her previous flat in central London for 60 years and consistently expressed a wish to go home. She was admitted to care due to her increasingly challenging behaviour towards carers, such that care could no longer be provided to her in her own home.

Ms Sykes was a high profile member of the community all her life, described in the judgement as ‘a vegetarian from an early age; a lifelong feminist and campaigner for women’s rights; a Wren in the Fleet Air Arm; a committed Christian; a political activist who stood for parliament; a councillor on the social services committee of the local authority that now authorises her deprivation of liberty; the editor for 40 years of a trade union newspaper; a helper of homeless people and an advocate for them; and a campaigner for people with dementia, from with condition she now suffers herself’. (p5)

She was diagnosed with dementia in 2006 and made a ‘living will’ in the same year. She made a property and affairs LPA in 2011. The ‘living will’ made statements of an advance decision to refuse treatment in certain circumstances, such that the judge (DJ Eldergill) interpreted that she prioritises quality of life over the prolongation of life.

Guidance to her attorney within the LPA stated ‘I would not like my attorney to sell my property. My wish is to remain in my own property for as long as this is feasible’.

‘... it is **her** welfare in the context of **her** wishes and feelings, beliefs and values that is important. This is the principle of beneficence, which asserts an obligation to help others further **their** important and legitimate interests. In this important sense, the judge no less than the local authority is her servant, not her master.’

DJ Eldergill went on to talk about the need to make one last attempt at looking after Ms S in her own home: ‘Several last months of freedom in one’s own home at the end of one’s life is worth having for many people with serious progressive illnesses, even if it comes at a cost of some distress. If a trial is not attempted now the reality is that she will never again have the opportunity to live in her own home. Her home will be sold and she will live out what remains of her life in an institution. She does not want that, it makes her sufficiently unhappy that sometimes she talks about ending things herself, and it involves depriving her of her liberty.’

Cardiff County Council v Ross and Davies (Case number 12063905)

Peggy Ross was an 82-year-old woman with dementia who had recently moved into a residential care home. She continued to spend weekends at home with her partner of 20 years, who had arranged for them both to go on a cruise ship holiday. This was something they had done together on many previous occasions.

The local authority came to the view that Mrs Ross lacked capacity to consent to the holiday and that it was not in her best interests. They believed she was unable to appreciate the risks of going on a cruise.

The case came before the court on the Friday before the scheduled start of the holiday the following Monday, so it was heard at very short notice and without evidence from experts on Mrs Ross’s capacity.

Although the judge concluded that the local authority had not provided sufficient evidence to rebut the presumption of capacity, he went on to state that in any case, even if Mrs Ross lacked capacity, it would not be against her best interests to go on holiday.

'My strong impression is that her social worker and the staff at the home want to do the right thing for her but are focused on her safety and are acutely aware of things that might go wrong. Perhaps the prime example of this was the concern that Mrs Ross might 'wander' (as she undoubtedly has in the past when living alone) on the ship and go over the side. It was suggested, not without some force in my view, that this smacked of saying that her best interests were best served by taking every precaution to avoid any possible danger without carrying out the balancing exercise of considering the benefit to Mrs Ross of what, sadly, may be her last opportunity to enjoy such a holiday with Mr Davies. This led, in my view, to trying to find reasons why Mrs Ross should not go on this holiday rather than finding reasons why she should.' (para 13)

The judge laid significant weight on Mrs Ross's wishes and feelings, the evidence that Mr Davies had shown that he is able to look after her at the weekends, and that this could be their last opportunity to go on holiday together.

What is Less Restriction?

When thinking about and applying the final principle of the Act social workers need to ask themselves whether there is another, less restrictive, way to achieve the desired outcome and if there is, how this can be applied. Part of the social work role is to advocate for independence, autonomy and best interests and within a framework where others are making decisions on behalf of a person this becomes even more important.

Learning Activity: Less Restriction

Read the following scenarios and consider how you might apply the principle of less restriction to support Emily in this situation, consider safety and still support her wishes in relation to this activity.

Emily, 97, lives in a care home. She walks with two walking sticks, which affects her ability to carry out some activities of daily living. Emily gets up very early; members of staff help her wash and dress, then offer her tea. When she lived with her family, she would get up herself and then sit in the kitchen drinking cups of tea until the rest of the family got up.

Soon after arriving in her new home, Emily insisted on going into the dining room in the mornings and making her own tea. Staff were concerned that Emily was at great risk of falling or of scalding herself. The dining room is unsupervised at this time as staff are busy in residents' rooms. They cannot lock the dining room, as other residents like to go in and out. Emily could not understand why there was a risk, as she has always made her own tea. Making her own tea helped her feel at home in her new environment.

The House of Lords reported that they received less evidence in relation to this principle than any of the other key principles.

‘We received less evidence on this principle specifically, although the evidence we did receive tended to reiterate the themes already identified: the tendency by professionals to protect rather than to empower, the dominance of risk-averse decision making, the use of the Act to justify decisions already made, and the failure to follow the best interests process and place P at the centre of the decision.

The ‘least restrictive option’ principle was raised explicitly in relation to care for dementia patients. Professor [Richard] Jones referred to research “which showed that 60% or thereabouts of patients with dementia who were admitted to hospital were admitted from their home, but only 30% were discharged back to their home”.

This raised the question of whether the least restrictive option in such cases – a return home, with support – was adequately and routinely considered, and the extent to which concerns regarding risk as well as resources were allowed to lead decision making.’

Less Restriction: Case Examples

As a social worker practising in this area it is likely that you will be involved in considering less restriction as part of your best interest decisions with other colleagues. In these situations you will need to ensure that you consider the impact of restrictions and identify where other methods (for example the use of telecare/telehealth or other adaptations) could be used to minimise the restrictions placed on the individual.

Useful information: London Borough of Hillingdon v Steven Neary [2011] EWHC 3522 (COP)

This is a very well-known case where the judge criticised professionals for not using the principle of the least restrictive alternative, and as a result Steven remained in care for an extended period of time, in breach of his Article 5 right to liberty and his Article 8 right to private and family life. Many people will be familiar with this case; the details in brief are as follows.

Steven was a 21-year-old man with autism and a severe learning disability. He was cared for by his father, who provided for his high levels of care, with support from the local authority including day care and respite care.

In December 2009, a combination of increased difficulty managing Steven over the Christmas period, and Mr Neary becoming unwell and exhausted, led to Steven being placed, with Mr Neary’s agreement, in respite care for a limited period.

The short period of care turned into weeks and months with concerns expressed by Mr Neary about Steven’s ongoing placement away from home. The court judgement makes it clear that the local authority quickly came to the view that Steven should not go home, but this was not shared with Mr Neary.

An incident in April 2010 at the support unit in which Steven was placed led to an urgent authorisation under the Deprivation of Liberty Safeguards. A full DoLS assessment was undertaken and the first of three standard authorisations was granted over the course of the following six months.

The judge's comments that the first Best Interests Assessor (BIA1) raised the question of whether Steven should be at the support unit at all, but did not follow up on this, and did not consider a return home as an option. 'The standard form used for the report specifically states: *"You must consider whether any care or treatment the person needs can be provided effectively in a way that is less restrictive of their rights and freedom of action"* and makes reference to paragraph 4.61 of the DoL safeguards Code of Practice, which refers to the question of *"what other care options there are which could avoid a deprivation of liberty"*. She flagged up what became known during the hearing as 'the elephant in the room', which was whether Steven should be at the support unit at all. However, she did not follow up on this. She does not refer to the alternative of a return home as being an obviously less restrictive alternative. (para 74)

The judge was more critical of the best interests assessment prepared for the second standard authorisation (by BIA2). 'No reference is made to his wishes and feelings. No reference is made to Mr Neary's opposition to the placement... No reference is made to the possibility of a placement at home alleviating the need for a deprivation of liberty.' (para 96)

The third standard authorisation was granted in September, and the best interests assessor (BIA3) makes recommendations regarding an application to the Court of Protection (which was already being considered) and notes that an Independent Mental Capacity Advocate (IMCA) had been requested. However, the explicit option of home rather than the support unit as a less restrictive alternative was again not considered.

'The authorisation makes no reference to Steven's wishes or those of his father, nor to the possibility that deprivation of liberty would not be involved if he was at home.' (para 117)

While best interests assessors are under a clear obligation to consider the less restrictive options when undertaking assessments under the DoLS regime, this requirement extends to all professionals when considering decisions in the best interests of people who lack capacity to make decisions.

It is important that social workers do not allow the less restrictive option to become 'the elephant in the room' as happened in the Steven Neary case, and that this is a clear and explicit agenda item throughout the decision-making process.

The following examples are taken from a range of cases where less restriction was being explored and are intended to provide you with an overview of how this principle is being applied in practice and in court.

Case Examples: Less Restriction

Michael Jenkins is an 85-year-old man who has advanced dementia. He has been living with his wife and daughter (Karen) who have been caring for him as his condition has developed. His son David was also involved in supporting him, but following a violent incident with Karen has moved out and is no longer providing support.

He had been attending a day centre to provide respite for his carers, but he started to refuse to attend, and when he did attend, refused the care being offered. He has also started to refuse the care provided by paid carers coming into Mr Jenkins' home, placing ever-increasing strain on his wife and daughter. He needs full support with his personal care and is doubly incontinent. His behaviour has become more challenging and his wife and daughter have stated that they can no longer meet his needs and he requires nursing home care. Mr Jenkins lacks capacity to make decisions on his accommodation and care, and an initial best interests decision was made to admit him to a nursing home local to his family who can visit regularly.

Since admission to the nursing home, Mr Jenkins has regularly refused care from the carers and they are finding it extremely difficult to look after him. His son David lives in the north of England but has returned to provide care in the care home, which Mr Jenkins accepts. However, the relationship between David and his mother and sister has irrevocably broken down, such that they visit Mr Jenkins at different times and have accused each other of various forms of abuse of each other and their father. David states that he can look after his father himself at his home in the north of England, and has a partner who has experience in looking after people with dementia. Karen and Mrs Jenkins oppose this, stating that David will be unable to manage the care and that David is violent and unpredictable.

A further best interests decision needs to be made regarding Mr Jenkins' future care and accommodation. The issues are who is best placed to manage Mr Jenkins' care, and what will be the impact on him leaving his home area and proximity to his wife of many years. Consideration needs also to be given to the least restrictive option for Mr Jenkins.

He is currently in a nursing home for people with dementia but has daily contact with his wife and daughter. He has, however, been regularly refusing care from the staff at the home, placing his physical wellbeing at risk. His son David argues that he can look after his father in his own home with the support of his partner, and living in his own family environment will be a less restrictive option than living in institutional care.

This example does not provide a simple answer where all parties are satisfied with the solution, but aims to reflect the difficult decisions that have to be made where there is tension and conflict between different parts of a person's network.

Serious consideration needs to be given to the fact that the option to live with Mr Jenkins' son would potentially be a less restrictive option, and therefore must be seriously considered. However, the other factors such as Mr Jenkins' relationship with his wife and daughter, and his son's unproven claims to be able to care for him, must also be taken into consideration.

Case Example: Less Restriction

Bernard is a young adult with autism combined with a severe learning disability. He has some challenging behaviours and has been living in institutional care for most of his life. He has recently moved to a new care home because the previous home had been unable to manage his behaviours. He has a history of running off from both staff and his parents, putting himself at considerable risk when this happens.

In his previous care home Bernard was not allowed out of the premises at all, due to the concerns that he would run away and put himself at risk. However, in the new facility, there is a structured programme of gradually increasing times in which Bernard is taken out with staff support. A body harness continues to be used, as it was in the previous home, but the two staff supporting Bernard stay close by him and link arms to reduce the visibility of the harness and maximise his dignity. The intention is to stop using the harness once a safe regime has been established.

The consideration here is to balance the need for Bernard to remain safe, in the context of his well established history of running off from his carers, while allowing him maximum freedom of movement and minimising any stigma associated with the methods of restraint used.

Careful consideration is given to the use of restraint, which is necessary to prevent harm coming to Bernard, but needs to be proportionate to the likelihood and seriousness of the harm of which he would be at risk.

Case Examples: Less Restriction

Jean's Story

Jean is an 87-year-old woman with advancing dementia in long-term care and has recently moved from another care home due to her deteriorating condition. She is prescribed a number of different medications for her various health conditions. Her prescription includes psychotropic medication to manage her anxiety when she becomes more agitated.

It is noted that her mental state deteriorates during the afternoon and this is when she tends to be given the 'prn' (as necessary) medication for her anxiety. The impact of this medication is that her anxiety reduces, but she also becomes sedated and sleepy for the subsequent few hours into the early evening.

However, the availability of alternative activities to keep Jean alert and occupied during this period appears to reduce the incidence of agitation and disturbed behaviour. A reduction in the frequency of administration of the psychotropic medication increases Jean's alertness during the latter stages of the day and reduces the restrictions caused by the sedating nature of the drugs.

Margaret's Story

Margaret is an 85-year-old woman living alone in her own accommodation. She has advanced dementia and has been living in this house for the past 47 years. Her husband died 10 years ago but they had lived there together for most of their married life and brought up their family there.

Margaret now has very poor short-term memory and while she understands that this is home, does not know where she lives and is disoriented in time. She recognises her family when they come to visit and enjoys their company. Her grandchildren also visit regularly and family members spend much of the weekend with her in her home.

Margaret on occasion believes that this is not her own home and leaves her house to look for her own home. She has gone out at various times of the day and night, sometimes wearing inappropriate clothing for the time of year, and the emergency services have had to be called to find her and bring her back.

Consideration has been given to a placement in a care home to address the increasing level of risk to which Margaret is subjecting herself.

There is concern that Margaret's disorientation will be exacerbated by her removal into care, and her episodic belief that she is not in her own home will become much more frequent (as it will be the reality of her situation) and her levels of anxiety and agitation will deteriorate. An alternative proposal is to put a keypad lock on Margaret's own front door, which she would not be able to operate due to her cognitive impairment. The family and care workers would be able to gain access via the code. The keypad could be linked to the heat and smoke detectors in the accommodation, such that in the event of a fire, or any of those detectors being activated, the front door lock would deactivate, thus allowing Margaret out of the house.

Commentary

While this scenario raises questions of deprivation of liberty and risk, the proposal should be considered in the context of a less restrictive alternative to long-term institutional care, and after taking into account the restrictions involved, whether on balance the risks of moving into care outweigh the risks of remaining in her own home.

Reflective exercise:

- ✓ How often do you explicitly consider all the options available, including those options that appear not to be realistic but would be less restrictive?
- ✓ What methods do you use to consider the relative merits of different alternatives, and whether one is more or less restrictive than another?
- ✓ How do you balance the level of restriction with the degree of safety provided by different alternatives?

Summary

These materials have explored the key principles and provisions of the Mental Capacity Act 2005 and considered how social workers can apply this principle to their practice.

It is important to remember that the onus is on the social worker to demonstrate that the person lacks capacity and provide evidence to support their conclusions; not on the person to demonstrate they have capacity.

All assessments under the Act should be underpinned by the guiding principles. In the case of the assessment of capacity this is that you approach decisions with the presumption that the person is able to make decisions for themselves. Where this is not the case your assessments must be decision specific, with each decision needing to be assessed following the statutory criteria.



Remember! *The starting point for any social work interaction or intervention should be the presumption that the individual is able to make his or her own decisions.*

Where there is a need to undertake a capacity assessment, practitioners need to consider each element of the two-stage test and ensure that they involve the person, consult others – informal supporters and professionals – where appropriate and provide evidence to support their judgements.

Reflective exercise:

Referring back to the reflective exercises at the start of these materials, after working through this module consider the following questions:

- What are your key learning points from this module?
- Have your views/attitudes changed as a result of the information and activities in this module?
- How will this learning impact on your social work practice?

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Further Resources

SCIE Mental Capacity Act Resource Hub:

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

SCIE Guide 42: Good Practice Guidance on Accessing The Court of Protection:

<http://www.scie.org.uk/publications/guides/guide42>

SCIE Guide 32: Practice Guidance on the involvement of Independent Mental Capacity Advocates (IMCAs) in safeguarding adults:

<http://www.scie.org.uk/publications/guides/guide32/files/guide32.pdf>

ADASS: Safeguarding Adults – A national Framework of Standards for Good Practice and Outcomes in Adult Protection Work:

http://www.adass.org.uk/adassmedia/stories/Safeguarding%20Adults/Safeguarding%20Adults%20benchmarking%20tool%2001%20_2_.pdf

CQC Briefing on 2014 Supreme Court Rulings Cheshire West etc:

http://www.cqc.org.uk/sites/default/files/20140416_supreme_court_judgment_on_deprivation_of_liberty_briefing_v2.pdf

MIND Guide to the Mental Capacity Act:

<http://www.mind.org.uk/information-support/legal-rights/mental-capacity-act-2005/>

Mental Health Foundation:

<http://www.mentalhealth.org.uk/>

Essex Autonomy Project:

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http://www.mentalhealthlaw.co.uk/Main_Page

Alex Ruck Keene's blog:

<http://www.mentalcapacitylawandpolicy.org.uk/>

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Court of Protection: Government website:

<https://www.gov.uk/court-of-protection>

Guide to the Court of Protection:

<http://sites.cardiff.ac.uk/wccop/>

This website accompanies a useful book about the Court of Protection:

<http://courtofprotectionhandbook.com/>

Lucy Series blog:

<http://thesmallplaces.wordpress.com>

Full judgements can be accessed via Mental Health Law online:

http://www.mentalhealthlaw.co.uk/Main_Page

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