

# Demystifying capacity

A guide for health and social care professionals

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# The principles of the Mental Capacity Act

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- Presume capacity
- Support individuals to make their own decisions
- Incapacity is not based on unwise decisions
- Decisions based on Best Interest
- Less restrictive options

# Consent to care and treatment – supported decision making

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Gaining informed consent to care and treatment is fundamental to the legal and professional obligations of health and social care practitioners and to the human rights of individuals.

Supported decision making is important to the process of informed consent – particularly where a person is not able to verbalise their views, make their choice and decision clear or when they have variable conditions which may result in fluctuating capacity.

# Decision for those who lack mental capacity

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If it is not possible to support the individual to make their own decision, because they lack the mental capacity to consent to the care and treatment, there are a number of provisions within the MCA to legally proceed with care and treatment proposed.

The individual may:

- Have created an Advance Decision to Refuse Treatment (ADRT)
- Have an appointed Lasting Power of Attorney for Health and Welfare (LPA) or
- Have a Court Appointed Deputy with welfare powers

# Best interest decisions

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Where a person lacks mental capacity to consent to care and treatment (including restraint and deprivation of liberty) and there are no other legal provisions for decisions to be made on their behalf, decisions regarding care and treatment must be made under Best Interest principles.

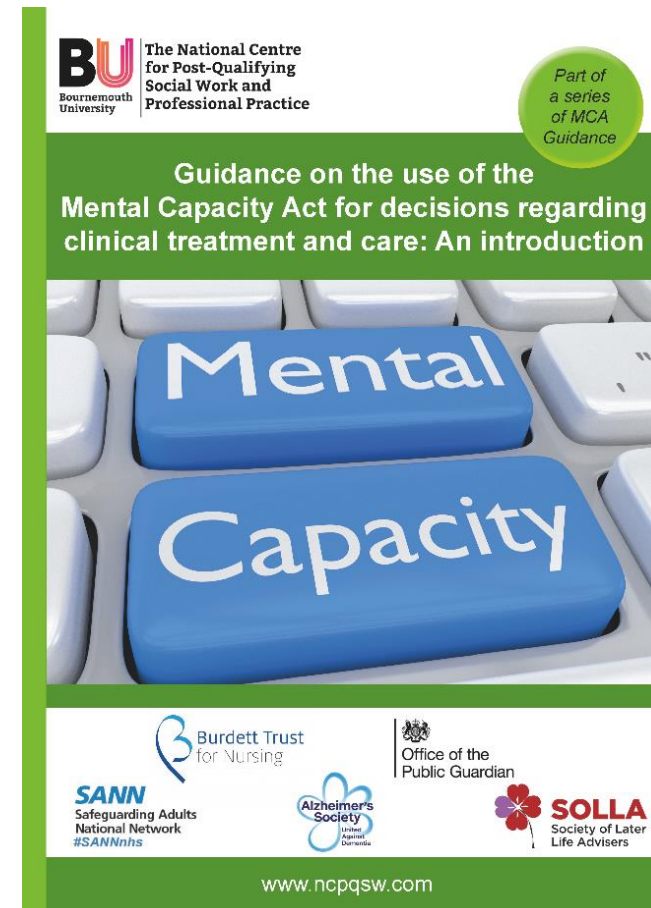
The process of making a Best Interest decision should involve a range of people, including the person who lacks mental capacity, their family/friends and /or advocates.

The Best Interest principles should lead to a more collaborative, comprehensive, better informed and person-centred care and treatment.

# Resources freely available



Available on the NHS  
Futures Platform or  
[www.ncpqsw.com](http://www.ncpqsw.com)



# Resources freely available

## Advance Decisions to Refuse Treatment



Suggestions on the value and use of  
ADRTs in society

[https://ncpqsw.com/  
publications/advance-  
decisions-to-refuse-  
treatment/](https://ncpqsw.com/publications/advance-decisions-to-refuse-treatment/)

## Next of Kin: Understanding decision making authorities



[https://ncpqsw.com/  
publications/next-of-  
kin-understanding-  
decision-making-  
authorities/](https://ncpqsw.com/publications/next-of-kin-understanding-decision-making-authorities/)

# Demystifying Mental Capacity

Set against the backdrop of the Mental Capacity Act 2005, this book explores and addresses issues raised by mental capacity within adult safeguarding, and provides clear guidance on the use and value of the MCA, and how to ensure that the rights and choices of individuals are heard, listened to and acted upon.

With contributions from a range of subject experts across the legal, social work, nursing and healthcare disciplines, this book will be invaluable to practitioners in the health and social care profession, and indeed any role where issues of mental capacity may be a concern.

Case studies, reflection points and exercises are used to develop understanding and support critical engagement with practice.

## Demystifying Mental Capacity

*A guide for health and social care professionals*

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Series Editor  
Keith Brown

*Post-Qualifying Social Work Practice*



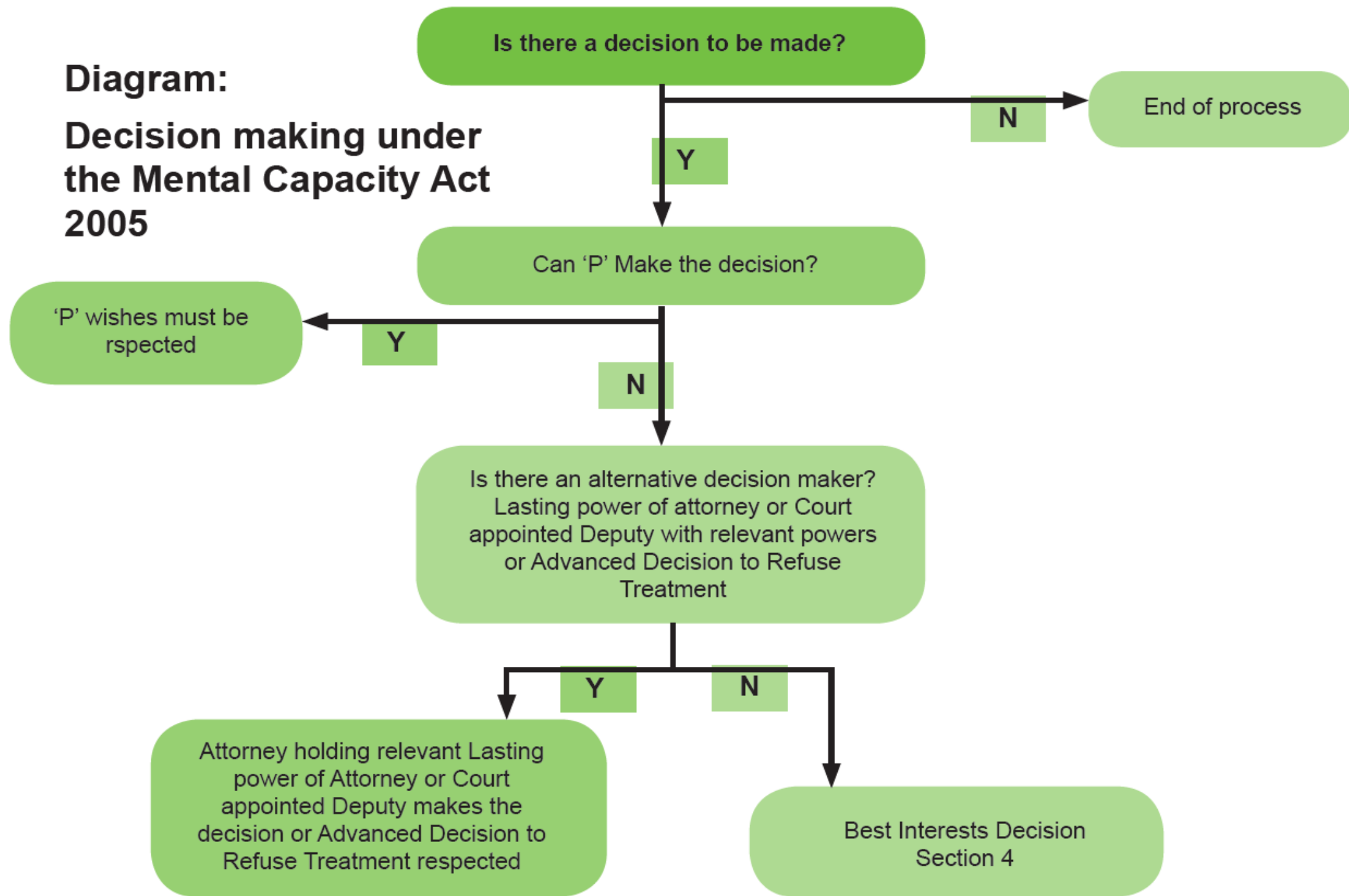


## The Mental Capacity Act requirements when an individual lacks the mental capacity to consent to treatment and care



## Diagram:

### Decision making under the Mental Capacity Act 2005



## Advance Decisions to Refuse Treatments

Advance Decisions to Refuse Treatments (ADRT) may have been made by an individual, regarding any treatment including life-sustaining treatment, to be considered at a future time when they may lack mental capacity to refuse treatments. ADRTs must be made when the individual has mental capacity to make an informed decision to refuse a treatment; they cannot be used to request or demand treatments, nor can they be used to refuse general care and treatment such as the provision of food, fluids, personal care (The National Centre for Post-Qualifying Social Work & Professional Practice - 2019). Where individuals have made clear statements, perhaps to others at a time when they had the mental capacity to do so, to refuse certain treatments through an ADRT, the clinical team must abide with this refusal of treatment. Treatment which has been commenced in advance of the discovery of an ADRT should be discontinued as long as the clinician is happy that the ADRT is “valid and applicable”.

# Advanced Decisions to Refuse Treatment

It is important to remember that an ADRT may not be in the form of a written document. Verbal ADRT are legally binding in most circumstances. The exception is life-sustaining treatment. In this instance, the ADRT has to be in writing, be witnessed by a third party and contain a statement which acknowledges that “this ADRT stands even if my life is at risk”.

## Lasting Power of Attorney for Health & Welfare

A person who lacks capacity may have appointed a *Lasting Power of Attorney for Health & Welfare (LPA)*. This person(s) may have legally binding powers to make decisions on behalf of an individual, regarding medical care and treatment, including life-sustaining treatment, ongoing care provision, long-term changes to a care setting and any issues/complaints/safeguarding concerns regarding care provided.

Nurses and other health and social care practitioners need to ascertain if an individual has anyone nominated as an Attorney for Health & Welfare under a LPA, as these people play a vital and legal role and are likely to be the 'decision-maker' for the clinical decisions of people unable to consent to care and treatment themselves; they need to be involved in all clinical decisions and their opinion and decision sought by the clinical team and clinical decision-maker (Griffiths 2017; NICE 2018).

## Lasting Power of Attorney for Health & Welfare

As stated above, if an Attorney with the relevant powers exists, they are likely to be the decision maker, thus negating the need for the best interest decision process outlined below. Attorneys are still charged with acting in the individual's Best Interests, but the professional role becomes one of support to the Attorney in making that decision rather than making the decision themselves. It is important not to take the existence of LPA at face value. Professionals need to satisfy themselves that the LPA is registered by the Office of the Public Guardian and need to identify the scope of the powers donated. For further information see <https://www.gov.uk/government/organisations/office-of-the-public-guardian> and <https://www.gov.uk/find-someones-attorney-deputy-or-guardian>



## The Court of Protection

The Mental Capacity Act (2005) also introduced a new Court of Protection, with legal powers to approve LPAs and a duty to preside over difficult or contentious decisions regarding serious medical treatment or care. A Court Appointed Deputy for Welfare may be appointed, to work with the clinical teams, where there is no appropriate LPA and ongoing decisions are required regarding complex or contentious clinical treatments. Deputies with welfare powers are likely to be less frequent than Attorneys with these powers as the Court prefers treatment decisions to be taken by multi-disciplinary teams in conjunction with the persona and their family and friends.

## Clinical decisions requiring referral to Court of Protection:

- Proposal to withhold/withdraw clinically-assisted nutrition and hydration from patients in Prolonged Disorder of Consciousness (PDOC), where there is disagreement or contest from the person's family or between clinicians. If there is full agreement within the clinical team, family and friends that continued treatment is not in the person's best interest, withdrawal can be done without court involvement (*An NHS Trust and others (Respondents) v Y (by his litigation friend, the Official Solicitor) and another (Appellants) [2018] UKSC 46*).
- Organ or bone marrow donation by a person who lacks capacity to consent to donation.
- Proposed sterilisation of a person who lacks capacity.
- Cases where there is doubt or dispute about a proposed treatment being in the best interests of the person without capacity (MCA Code of Practice (2007) Department for Constitutional Affairs).



## Independent Mental Capacity Advocates

Where the individual who lacks capacity to consent to treatment and care has no appropriate family or friends who are willing to support them, nor a Lasting Power of Attorney or Court Appointed Deputy with the relevant powers, the clinical team may need to engage and involve an Independent Mental Capacity Advocate (IMCA). The IMCA serves to meet with the individual, clinical team and other relevant people, to provide an independent and objective view of the individual's wishes, beliefs and former decisions, in order to work with the clinical team to protect the person's rights and agree the Best Interests for specific clinical decisions. The IMCA will never be the decision maker.

When is IMCA involvement required?

- When an individual lacks mental capacity to consent to treatment and care.

AND

- The person has no family/friends who can be involved in decisions, or no LPA or Court of Protection deputy in place.
- For clinical decisions regarding serious medical treatments.
- For the detaining of an individual in a clinical setting for treatment or care.
- When there are proposed long-term changes to the care setting/accommodation (MCA Code of Practice - Department for Constitutional Affairs 2007).

# Independent Mental Capacity Advocates

However, it is common for patients who lack mental capacity to consent to the care and treatment they need, to present with no ACP or ADRTs in place, no identified LPA for Health & Welfare or without a Court Appointed Deputy. Family members, those identified as Next of Kin, care staff and even friends and neighbours, may all be highly relevant and appropriate to be involved in decision-making – but without the legal power of LPA for Health & Welfare, or without an ADRT or ACP, they have no legal rights to make the decision for the individual. For further information see The National Centre for Post-Qualifying Social Work (2018b).

## Best Interest Decisions

The MCA (2005) is clear that an individual should be given support and practical help to make the decision regarding care and treatment themselves. Even if the person is unable to make the decision themselves, they should be encouraged and supported to be actively involved and included in the decisions (Brown et al. 2015). The decisions made for care and treatment for an individual who lacks mental capacity to consent, should follow the Best Interest principles as laid out in the MCA Code of Practice (Department for Constitutional Affairs 2007). The Best Interest checklist ensures that the process of decision making is fair, person-centred, with consideration of the individual and their wishes.

## What is the Best Interest Checklist?

- Encourage participation.
- Identify all relevant circumstances – understand the individual and their likely views/wishes.
- Find out the person's views – past and present wishes, known beliefs and values, previous decisions and actions taken.
- Avoid discrimination – decisions should not be made simply on grounds of age, condition, gender, race.
- Consider if the person is likely to regain mental capacity - can the decision be delayed until the person has capacity to consent.
- Does the decision concern life-sustaining treatment – the decision should not bring about the person's death.



## Best Interest Checklist, continued

- Consult others – anyone previously named by the individual, family, friends, an LPA or Court Deputy.
- Where the decision is regarding serious medical treatment or long-term accommodation and the individual has no-one available to be involved (they are deemed as ‘un-befriended’) an IMCA must be consulted and involved in the Best Interest decision.
- Avoid restricting the person’s right – consider if there is a least restrictive option.
- Weigh up all of the above, to make a considered decision based on the person involved.

(Based on MCA Code of Practice –Department for Constitutional Affairs 2007).

The Best Interest checklist provides a guide for good practice, to ensure that care and treatment undertaken for an individual who lacks the mental capacity to consent, remains lawful and person-centred. When urgent care and treatment need prompt decision making, with no time to consult others, explore the individual's known wishes or make referral for an IMCA, the clinical team should still ensure that:

- Treatments and care are as less restrictive and least invasive as possible.
- Clinical decisions are not based on assumptions and discrimination.
- The individual's family are informed and involved at the earliest opportunity.
- Clinical decisions are made to provide the optimal outcomes for the individual.
- Clinical decisions involve relevant health and social care practitioners available at the time of urgent treatment or rapidly declining condition.
- Ongoing and further decisions are made following Best Interest principles.

Practitioners should ensure that every effort is made to help individuals make their own decisions, wherever possible. It is only when a person is shown to lack capacity to consent to their treatment or care, that the clinical team need to look for legal arrangements, as set out in the MCA, for alternative decision making. It is only with the lack of any alternative legal provision for decision making, that the MCA Best Interest checklist becomes relevant. At all times, the clinical team should follow the principles of the MCA – to ensure a person-centred approach to care, in which decisions are made jointly with the person and other relevant people; that treatment and care are the least invasive and restrictive and in line with the person's known wishes, beliefs and values as far as possible.



# Conclusion

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- It's all about informed consent
- Do make use of the materials available
- Do think about your own LPA health and welfare (and for your loved ones)
- Consider also LPA property and finance