Mental Capacity Act 2005

- Practice Guidance -



Central Bedfordshire

Mental Capacity Act 2005 - Practice Guidance.

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Service			
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Introduction

This document is a combination of best practice guidance and external resources to assist practitioners when using the Mental Capacity Act 2005 (MCA 2005). It applies to all Central Bedfordshire Council employees working with people over the age of 16 and should be considered jointly with the MCA 2005 Code of Practice DoLS Codes of Practice, [1]CBC Mental Capacity Act 2005 policy[2] and CBC Mental Capacity Act 2005 competency framework.[3]

This document is based upon the law as it stands at publication (or stated review dates); it is intended as a guide to good practice, and is not a substitute for legal advice. Advice and support will still be required from line management and or legal services on a case by case basis.

Setting the scene.

The MCA 2005 has been in force since 2007 and applies to England and Wales. The primary purpose of the MCA 2005 is to promote and safeguard decision-making within a legal framework. The MCA 2005 has five statutory principles which can be separated into two broad parts –

1. The first three principles: apply to all people, all the time.

Section 1 of the Act: The Principles

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

2. A person is not to be treated as unable to make a decision unless **all practicable steps to help** him to do so have been taken without success.

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

4. An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his **best interests**.

5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of **the person's rights and freedom of action.'**

[1] MCA and DoLS Codes of Practices
[2] available at http://intranet.centralbedfordshire.gov.uk/council-services/directorates-service-areas/social-care-health-housing/policyplans/policy-framework/default.aspx

[3] available at http://intranet.centralbedfordshire.gov.uk/council-services/directorates-service-areas/social-care-health-housing/policyplans/policy-framework/default.aspx

- protecting the rights of people to make their own decisions wherever possible;

2. The latter two principles: apply to <u>those people assessed as lacking mental capacity</u>.
   - protecting the rights of people to be supported to participate in decisions made on their behalf, and for any decisions to be in their best interests and least restrictive of their rights and freedoms.

The spirit and intention of the Act can be summarised as:

> ***'enabling and supportive of people who lack capacity, not restricting or controlling of their lives' (Department of Constitutional Affairs, 2007)***

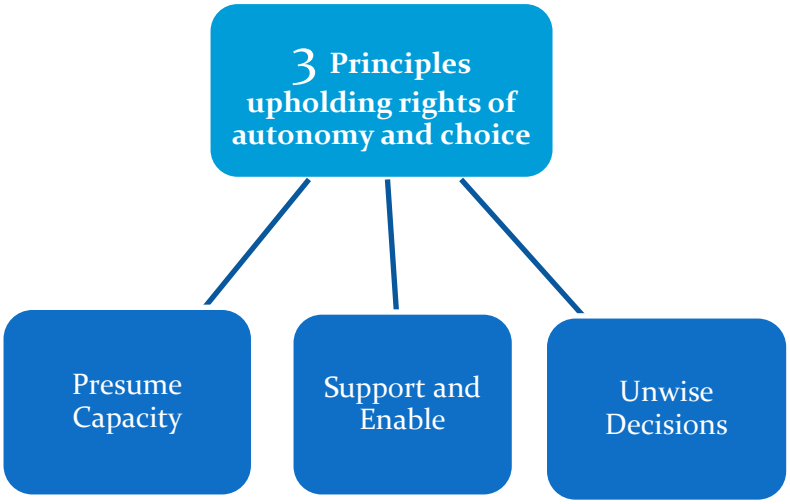
It is generally accepted however that the *'prevailing cultures'* of risk aversion have prevented the Act from becoming widely known or embedded.

> ***'The empowering ethos has not been delivered. The rights conferred by the Act have not been widely realised. The duties imposed by the Act are not widely followed.'(House of Lords, 2014)***

The purpose of this practice guidance is to support Central Bedfordshire Council employees to have greater understanding of the Act; so that its rights are realised, duties are followed and empowering potential delivered.

Part 1

The first three principles applied in practice:



The first three principles of the Act are fundamental to how a practitioner should first approach any situation; best considered and applied collectively. They are all part of the same empowering spirit – respecting autonomy and requiring assisted decision making.

3 Principles upholding rights of autonomy and choice

The first three principles are collectively paraphrased as:

> **Assume** capacity regardless of any particular decision(s) the individual is making, even if considered to be **unwise**, and provide the individual with **all practical support** and help to make their own decision.

1.1 Presume capacity and Unwise decisions

The first and third principles - presume capacity and right to make unwise decisions - go naturally together. The assumption of capacity is most challenged when an individual is making what might be considered unwise or irrational decision(s).

The first and third principles are the defender of individual autonomy against potentially risk-averse or paternalistic practice. They remind the practitioner that where an individual has mental capacity, but is refusing intervention or offers of assistance, they have no authority under the MCA 2005 to act without their consent. This stands regardless of whether the situation involves matters of adult safeguarding or other concerns.

It is best practice to approach every situation with this in mind, but, it does not mean that mental capacity assessments should not be carried out where appropriate (e.g. the person's behaviours or circumstances cause doubt or concern). This is further discussed in Part 2 of this practice guidance '*When should mental capacity be assessed?'*

The MCA 2005 Code of Practice states that:

> ***'It is important to balance people's right to make a decision with their right to safety and protection when they can't make decisions to protect themselves. But the starting assumption must always be that an individual has the capacity, until there is proof that they do not.' (MCA 2005 Code of Practice, para 2.4, p21).***

POINT for REFLECTION:

It is vital for all practitioners to acknowledge the need to be 'self-aware' - to consider how personal views or opinions have potential to result in assumptions about age, appearances, conditions or behaviours in terms of mental capacity?

Reflect on what assumptions you might have made in the past and consider how you can overcome them to ensure they do not prejudice assessments of capacity.

The Social Care Institute for Excellence (SCIE) website has a short film illustrating 'respecting the right to make "unwise" decisions' in domestic setting. http://www.scie.org.uk/publications/mca/decision-making/unwise-decisions.asp

1.1 (1) Working with people who choose to remain in situations of risk or concern.

Working with people who choose to remain in situations that involve risk can be very challenging. There have been several cases where the courts have been highly critical of local authorities for either, doing too much (and acting without consent) or doing too little (using the presumption of capacity incorrectly). This can be a delicate tightrope to tread.

Where individuals are assessed to have mental capacity, in the related matter, it is advisable that practitioners remain involved where significant risks remain. Giving, for example, consideration to alternative ways to reduce or eliminate the concerns within the limitation of their consent. Approaches that may produce positive outcomes include:

- Persistence in building a relationship of trust over time can gradually accept support;
- Understanding of the individuals history and journey into their situation will allow a more personalised intervention; and,
- A proportionate response to the risks may be more successful than seeking to remove all risk.
  (Braye et al. 2014)[4]

A determination of a person having capacity should not necessarily result in the practitioner withdrawing. It is vital that practitioners are able to assess the situation as a whole, try and build up a rapport with the individual, and clearly measure and record the remaining risks. The support practitioners provide should never be presented as a one-time, or, all or nothing offer. People make choices and practitioners should support them through those decisions; working with them at their own pace.

[4] Braye, s., Orr, D., and Preston-shoot, M. Self-Neglect Policy and Practice: Building an Evidence Base for Adult Social Care. London: SCIE

We are working within the individual's consent, whilst also monitoring any concerns. We are guests in people's life not intruders.

A risk assessment and safeguarding plan should be drawn up with the person and where risks remain it may be advisable to discuss the situation with our legal team for guidance on options to take. In certain circumstances the High Court should be considered with a view of requesting an Order under its Inherent Jurisdiction powers –for example, to protect a person with mental capacity who might be considered as 'vulnerable' and experiencing coercive or controlling behaviour – however it is a good idea to seek legal advice on a case by case basis. For further reading, please see, Essex Autonomy Project, 2011[5]

POINT for REFLECTION:

One person's unwise decision is another's acceptable risk-taking: consider when, in your practice, you have come across someone with a different attitude to risk than you, or values certain aspects of life differently? Reflect on how the person may simply have been considering matters from their own point of view.

'Everybody has their own values, beliefs, preferences and attitudes.' (para 2.10, CoP, p24).

[5] https://autonomy.essex.ac.uk/resources/vulnerable-adults-and-the-inherent-jurisdiction-of-the-high-court/

1.2 Support and enablement in decision making

The primary objective of the Act is to ensure that people remain in control of their own lives as much as possible: 'Supported decision-making; not hijacked decision making' (Baker, D. 2017). This requirement of maximising a person's ability to make their own decisions, enabling them to have legal capacity, comes from the second principle:

'A person is not to be treated as unable to make a decision unless all practicable steps to help him (or her) to do so have been taken without success.'

For practical consideration, examples of 'steps to help' have been separated into two broad areas: 1) information, and, 2) support.

1.2 (1) Information (all people, all the time).

Where there are decisions to be made, individuals require the right information and support to understand and choose between available options in a clear and transparent way. Having the right information at the right time, and communicated in the right way, is an integral part of supporting people to make decisions. People should not be expected to make decisions with insufficient information.

In *CC v KK* [2012] EWHC 2136 in the Court of Protection Baker J. emphasised the need to present the options to the person concerned and not to start the assessment with a 'blank canvas.'

Such information will inevitably include, as a minimum, details of:

- the nature of the decision (including options available)
- the reason why the decision is needed, and
- the likely effects of deciding one way or another, or making no decision at all.

…*before* a decision can be made by the person. Good decision-making relies on good information.

Please consider the tools at appendix 1 to help think about and or record the information provided to an individual about a particular decision.

POINT for REFLECTION:

In each situation, consider what information would the average person expect to have when making a similar decision – have you been able to obtain this information in an appropriate format for the person?

For example, have all required assessments been completed to assist the person making an informed decision? And, all the available options to meet eligible care and support needs have been clearly outlined?

Chapter 2 and 3 of the MCA 2005 Code of Practice.

1.2 (2) Support: (All people, all the time).

What other practicable steps can be taken? Drawing upon the guidance provided in the MCA 2005 Code of Practice, at chapter three, the following eight broad areas of practical considerations and support can be identified. These are explored on the following page using the acronym of '**HELPED.**'

Hour **H**	Are there particular times of day when the individual's understanding is better? This will include consideration of the positive and negative effects of any relevant medication. Changes or patterns in mood throughout the day? Distractions relating to daily routine? Are there unnecessary time pressures and time frames being placed upon the individual? Consider if the decision can be put off until a later time when circumstances are right for the person?
Environment **E**	Are there particular locations where the individual may feel more at ease? Are there particular locations that will make elements of the decision easier to understand? Depending upon the nature of what is being discussed, is the environment private and respecting confidentiality so the individual feels able to talk freely. Relaxed and comfortable without unnecessary distractions.
Language **L**	How does the individual best receive information? How does the individual best express their views and opinions? It is of value to consider these as two separate elements because some individuals may prefer one form of communication to receive information and another to express their views and opinions. Are translator or interpreter services required? Consider whether any specialist assessments are required, for example Speech and Language? Consider pictures and other tangible aids?
People, Programmes and Person-centred Planning tools **P**	<u>People:</u> Can anyone else help or support the person to feel more at ease, make the required decision or express a view? For example, family or friends. Advocacy – The Care Act 2014 introduced the provision of advocacy support for those that, regardless of mental capacity, have no one appropriate to support them and they have 'substantial difficulty' with participating in the assessment, planning, care review safeguarding enquiry or safeguarding review processes. <u>Programmes:</u> It should be considered whether there are programmes or training courses that might improve the individual's understanding of their situation or decision (in the short or longer term). <u>Person Centred Planning/Decision-making tools:</u> These can provide a practical way of supporting an individual in understanding their own situation and make their own decisions.
Equipment **E**	Are there any equipment or aids that will assist with the decision making process? This might include communication aids; pictures or photographs.
Diagnosis **D**	Would any medical or clinical support, including treating a medical condition, help improve the individual's capacity?

1.2 (3) Creative enablement.

Of the many practical steps that have been identified, creative person-centred/ decision-making tools are, perhaps, the most underused and yet potentially helpful strategies to promote engagement.

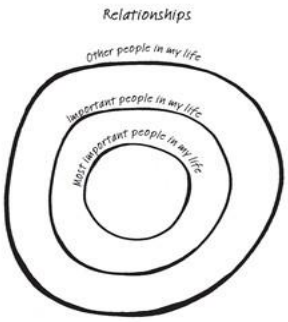
When considering how best to promote a person's ability to make their own decisions (or directing and influencing any decisions made own their behalf), practitioners should embrace their creative side and consider how to promote better interactions with people – beyond traditional conversations – in order to meet people where they are at. Consider diagrams, pictures, activities, everyday objects, that promote meaningful exchanges with that individual.

> ***It is not so much about traditional conversations, but connections; not words, but relationships.***

There is a need to move away from protection being the primary consideration of professionals, towards creative enablement; where support and assistance is the focus.

There are different tools to suit different people and situations and there will be times when practitioner may feel it appropriate to develop and create tailored tools or activities.





For inspiration, examples can be found in the helpful handbook published by Research in Practice for Adults (RiPfA) (Nosowska and Series, 2013). Helen Sanderson Associates[6] and 'In Control'[7] also have helpful resources on their websites.

[6] See, http://www.helensandersonassociates.co.uk/ (accessed on 27nd February 2017)

[7] See http://www.in-control.org.uk/resources/support-planning/person-centered-planning-with-older-people.aspx (accessed on 27nd February 2017)

In addition to formal tools, simple actions, that many practitioners do already to promote understanding and engagement (for example, grabbing the brochure of the care home to show the pictures of staff members, using equipment as a point of reference to talk about care and support needs or using maps on a tablet computer to explore understanding of different locations), can all make a difference in maximising an individual's understanding and enable greater thinking around their situation.

A good example, for further reading, can be seen in the case of *LBX v K, L & M [2013] EWCH 3230 (Fam) [26]*[8] in which the practitioner used drawings and prepared cards to "facilitate a more concrete conversation with L regarding his wishes and feelings".

Please consider the resources previously cited in the text and the tool at appendix 2. Consider these for inspiration and feel free to be creative. Remember, what works for one, may not be appropriate for another.

POINT for REFLECTION:

Think about how individual we all are in communication – some people might prefer visual (pictures, images), verbal (words, both in speech and writing) or physical (body, hands and sense of touch).

Then consider, in every situation:

How can you connect with the individual in a tangible and meaningful way? What is going to assist this individual to think around their situation and express themselves? What words, tangible items or activities might help explain the situation / decision or assist the individual to express how they see their own situation / decision?

[8] See http://www.mentalhealthlaw.co.uk/File:LBX_v_K,_L_and_M_(2013)_EWHC_3230_(Fam),_(2013)_MHLO_148.pdf

1.3 People taking control of future decisions

The Mental Capacity Act 2005 introduced Lasting Power of Attorney (LPA) and Advance Decisions (sometimes known as an advance decision to refuse treatment, an ADRT, or a living will).

These two provisions enable the wishes, feelings, beliefs and values of individuals to be carried forward and have future legal standing at a time when they lack mental capacity in a relevant matter.

Most people have very little idea of the importance of Lasting Powers of Attorney or Advance Decisions and both the House of Lords and the Government agree that the uptake of Lasting Powers of Attorney is too low: "Awareness needs to be raised among the general public of the benefits of Lasting Powers of Attorney in order to encourage greater take-up, especially for Health and Welfare matters" (House of Lords Select Committee, 2014).

1.3 (1) Lasting Power of Attorney (LPA)

This is a powerful provision within the Act, enabling a person to select people in their life to make future decisions when they are no longer able to.

- The person making the power of attorney is called a donor and the person(s) appointed to act on their behalf is called an attorney.
- The donor must have mental capacity in the related matter when making the LPA.
- The donor must be over the age of 18.
- There are two types: health and welfare; property and financial affairs.
- Separate legal documents are completed for each of these areas
- The LPA must be registered with the Office of Public Guardian (OPG) before it can be used.
- More than one person can be appointed to be an attorney for each aspect.

Lasting Power of Attorney (LPA) replaced what was previously called an Enduring Power of Attorney (EPA) under the previous law. The Enduring Power of Attorney

(EPA) was restricted to making decisions over property and affairs only. An EPA made before the Mental Capacity Act 2005 came into force (October 1 2007) remains valid.



When acting under an LPA, an attorney must:

- Make sure the Mental Capacity Act 2005 statutory principles are followed.
- Check whether the person has the capacity to make that particular decision for themselves and, if they do, it is not for the attorney to act (unless they have given agreement when making the LPA for property and financial affairs – this only applies to property and financial affairs).

NB: Once a person lacks mental capacity they can no longer make a Lasting Power of Attorney. A relevant person, interested in their welfare, would need to make an application to court to become deputy if they wanted to make decisions. There are two types of deputyship: Property and financial affairs; and / or, Personal welfare.

1.3 (2) Advance Decisions

An advance decision (sometimes known as an advance decision to refuse treatment, an ADRT, or a living will) allows someone aged 18 or over, while still capable, to refuse specified medical treatment in the future when they lack capacity to consent to refuse. It only applies to specific medical treatment and not general care decisions.

An advance decision does not have to be in writing unless the person wants to refuse *life-sustaining* treatment. In this case it must be in writing, signed and witnessed, and state clearly that they wish it to apply, even if their life is at risk.

An advance decision must be **valid and applicable** to the current circumstances, and, if it is, it has the same weight as a decision made by the person having capacity – meaning health care professionals must follow the decision or seek court approval to act to the contrary.

It is advisable for people making an advance decision to consider letting their family, friends and carers know about it.

1.3 (3) Advance statements of preferences

In addition to Lasting Power of Attorney (LPA) and Advance Decisions, people should also be encouraged to think about any specific will or preferences they may have about their future; and for family, friends and involved professionals, to be made aware of them.

Such insights may prove helpful to inform any future best interests decisions if the person is considered to lack mental capacity in the future. Although they are not legally binding they should be taken into account as part of the best interests decision-making process. Divergence, as part of a best interests decision, should be fully justified and only when necessary.

POINT for REFLECTION:

Health and Social Care practitioners have a key role for introducing and discussing these legal provisions – in particular, Lasting Power of Attorney (LPA) and Advanced Decisions (AD) - as part of their day to day work.

Consider how to embed into your practice positive conversations about future decision-making and the legal powers within these provisions.

LPA Sections 9-14 of the Act; AD - Section 24-26 of the Act

Part 2.

Mental Capacity: What is it? When to Assess? How to Assess?

2.1 Mental Capacity: What is it?

The definition of lacking mental capacity is provided in section 2 of the Act:

'For the purposes of this Act, 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 brain.***'



Mental Capacity is ***Issue Specific*** and ***Time Specific*** - about a real decision at the time it is required to be made.

Whether it is relating to day-to-day decisions, that affect daily life, or more serious or significant decisions, the same definition and 'test of capacity' applies.

2.2 Mental Capacity: When to Assess?

It is important to assess a person's mental capacity when there is an actual decision to be made and appropriate reasons cause doubt or concern.

Appropriate reasons might include:

a) The person's ***behaviour or circumstances cause doubt***

c) The person may have been ***assessed to lack mental capacity to make other decisions*** in their life.

d) The person repeatedly makes unwise decisions that put them at ***significant risk of harm or exploitation***.

e) The person makes a particular unwise decision that is ***obviously irrational or out of character.***

b) ***Other people have expressed concern*** about the person's capacity to make a particular decision.

NB: reasons cited in the MCA Code of Practice at p25 and p52.

The above circumstances do not mean that the person would necessarily lack capacity but may prove sufficiently concerning that an assessment should be carried out and recorded.

The important point is that good practice reflects the ability of practitioners to uphold the presumption of mental capacity, and the right of people to make unwise decisions, whilst also ensuring that they complete and record assessments of capacity when there is appropriate reason to doubt.

It is good practice to include in the assessment of capacity summary the reasons why it was considered necessary to undertake the assessment in the first place.

POINT for REFLECTION:

What behaviours or circumstances might cause doubt?

When have you worked with people that repeatedly put themselves at significant risk of harm or exploitation and ask yourself: *How did I respond?*

What further enquiries/assessments of capacity did you undertake whilst also upholding the MCA 2005 principles?

2.3 Mental Capacity: How to Assess?

The guidance document produced by Thirty Nine Essex Street lawyers is excellent reading for guidance on completing assessments of capacity. [9] They have referred to the assessment process as being 'In many ways, an attempt to have a real conversation with the person on their own terms, and applying their own value system' (Ruck Keene et al., 2016a).

Referring back to the definition of what it means to lack mental capacity, cited in section 2.1 of this guidance, there are three broad elements to how this should be understood and assessed:

1. An ***inability*** to undertake the decision making process (functional test)
    a. Assessing their ability to **understand** the information relevant to the decision.
    b. Assessing their ability to **retain** the information relevant to the decision.
    c. Assessing their ability to **weigh and use** the information relevant to the decision.
    d. Assessing their ability to **communicate** a decision (by any means possible) on the decision.
2. An ***impairment*** of, or a ***disturbance*** in, the functioning of the brain or mind (diagnostic test)

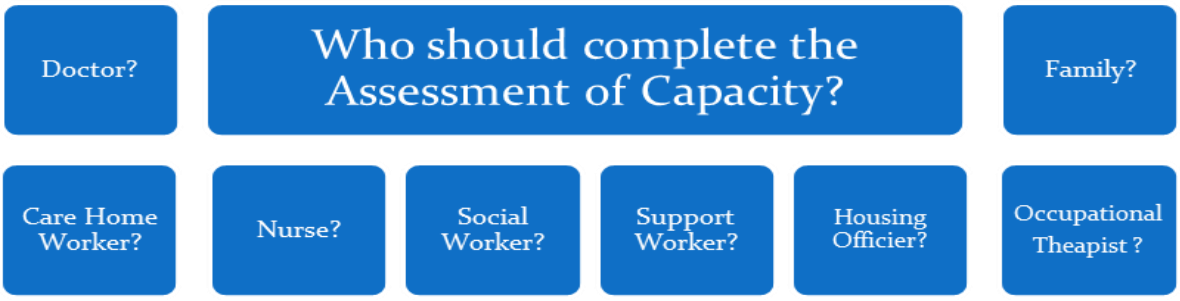
    And crucially…
3. The inability is ***because of*** the impairment or disturbance in, the functioning of the brain or mind (causation test).

If the individual being assessed is unable to do any of the four elements of the functional test, in relation to the specific decision at hand, and this is assessed as being because of their impairment or disturbance of the brain or mind, then the person will be considered to lack mental capacity to make that decision.

[9] Ruck Keene, A. et al (2016a) *'Thirty Nine Essex Street A brief guide to carrying out capacity assessments'* Thirty Nine Essex Street. Available at http:www.39essex.com/tag/mental-capacity-guidance-notes/ (accessed on 22nd November 2016)

The terms 'functional' and 'diagnostic' do not appear in the MCA 2005, although they are used in the Code of Practice, and the causation requirement ('because of') has been emphasised through case law[10].

2.3 (1) Who should complete the assessment of capacity?



The person responsible for carrying out the assessment of capacity will usually be the person directly involved at the time a decision is required. For example, medical decisions are for medical practitioners; social care decisions are for social care practitioners.

The assessor must be working within the scope of their expertise and knowledge.

There are times when it is helpful to share knowledge and good practice, about MCA 2005 processes and best practice with different professionals, but this is not the same as carrying out the assessment or making the best interests decision. For those that are professionally registered it is worth considering your registration and requirements to act within the scope of your knowledge.

This means that different people may be involved in assessing an individual's capacity about different decisions.

It is not for a social care practitioner, for example, to assess a person's mental capacity to consent to particular medication. Likewise, it would not be a doctor to assess a person's mental capacity about social care accommodation.

[10] See See *PC and NC v City of York Council* [2013] EWCA Civ 478 at paragraph 58 .

2.3 (2) Preparation of the capacity assessment

Before conducting any assessment of mental capacity it is advisable for the assessor to consider several points and ensure they first and foremost fully understand what they are assessing and how they plan to approach the assessment. It is not a matter of simply going out and having a discussion without any forethought.
The preparation required can be broken down into the following three steps:

a. **Define what the concrete decision is**
b. **Identify the 'salient factors' (the information required) for the person to make a fully informed decision**
c. **Consideration of how to conduct the assessment including what support might be required**

Define what the concrete decision is

What is the actual decision at hand? The decision should not be an abstract hypothetical scenario, but the reality of the actual situation and the reality of the actual available and realistic options.

The assessor should guard against limiting the decision in an artificial or biased sense, which means not framing the decision as if the individual only has the option of accepting or declining one particular option, which happens to be the professional's preferred option.

Example: Instead of 'to consent to moving into a care home,' the decision should be more concrete and inclusive of all options, such as, 'where to live, to receive the required care or treatment, considering the available options of X Y and Z' (with details of X Y and Z options being clearly outlined and communicated).

Identify the 'salient factors'/ information required for the person to make a fully informed decision.

It is advisable to write a list of the 'salient factors' of the decision before carrying out the assessment, so that the assessor can remain focussed on what is important and ensure that they are not setting the bar too high. Once the concrete decision has been defined, and options available understood, the assessor should consider what

the relevant information is in regards to each option and their circumstances. Case law has clarified this to be only the 'salient factors'[11] in terms of making the decision.

It is important to consider the reality of the person's circumstances and the likely foreseeable consequences of choosing one way or another. How will each option impact upon the person and their situation? Case law has used the illustration of ensuring that a person does not start from a 'blank canvas' – the assessor is responsible for ensuring that the decision is fully informed[12]

It is helpful to consider:

- **The individual situation and circumstances** – what information is relevant, do I have this information to hand?
- **Why a decision is considered to be required** – what information is relevant, do I have this information to hand?
- **The options available** – what information is relevant, do I have this information to hand?
- **Likely foreseeable consequences of choosing one way of another** – what information is relevant, do I have this information to hand?

Having identified the salient factors this then enables the assessor to move onto the next part of the preparation; ensuring the person is given all the required information to make their own decision.

The guidance document produced by Thirty Nine Essex Street, previously referred to, draws upon different court judgments and lists potential relevant information attribute to different types of decisions, including decisions about Sex, Residence, Contact and Care

'It is important not to assess someone's understanding before they have been given relevant information about a decision. Every effort must be made to provide information in a way

[11] *LBJ v RYJ* [2010] EWHC 2664 (Fam).
[12] *CC v KK & STCC* [2012] EWHC 2136 (COP).

that is most appropriate to help the person understand'.

(MCA Code of Practice, paragraph 4.16)

Consideration of how to approach the assessment.

The statute does not direct the method of assessment. However, typically, it is about trying to engage with the person in a discussion (in whatever form of communication they use) about the circumstances, options and foreseeable consequences of deciding one way or another. Furthermore, within this discussion/interaction the assessor is considering the 'test of capacity' referenced in this guide previously and given in section 2 and 3 of the Act.

It is also important that the requirement to be supportive and enabling, previously discussed in section 1.2 of this guidance, is also applied during any assessment of mental capacity. Refer back to the examples explored through the 'Helped' acronym and apply them to the assessment process.

Please consider the tools at appendix 3 for a table that may be used to consider each aspect of the test of capacity and how to maximise the person's abilities.

In some cases writing a set of pre-planned questions with space to record the person's actual responses might be helpful. This is advisable for more complex decisions with significant concerns, where a record of a person's exact responses can prove extremely valuable in evidencing what informed the eventual determination.

It may be helpful to reflect back on the list of 'salient factors'/ information previously identified to construct questions that both support the person in making the decision themselves whilst also seeking to evidence whether they understand, retain, weighing /using information to sufficient degrees. Naturally, the assessor will require some degree of flexibility, tailoring the discussions to the person's responses and abilities during any discussion, but previously considered questions may assist in framing the assessment and keeping focussed.

'It is important to note that questions can be used as a way of stimulating self-reflection - as a way of returning people to their own thoughts and their own knowledge base - because it is here that the kernel of self-determination and empowerment is located.' (Trevithick, 2005)

Consider the style of questioning and language used to get the fullest and most accurate picture. Practitioners should encourage people to communicate their views, thoughts and feelings at their own pace and in their own words. This often requires drawing upon a range of questions - open, focussed, prompts and closed - where appropriate. A useful free e-learning resource can be found on the SCIE website which explores different questioning styles.[13]

POINT for REFLECTION:

'Prompts' are often short phrases or nonverbal gestures that are used to encourage someone to continue to communicate.

These may be helpful when people are struggling to put things into words, or if they have worries about what they are saying.

Consider what verbal or non-verbal prompts you have used previously as well as what may be helpful to use in future assessments.

[13] See: https://www.scie.org.uk/assets/elearning/communicationskills/cs04/resource/html/object4/object4_4.htm#slide08

2.3 (3) Carrying out the mental capacity assessment.

It is important to start by explaining the purpose of the assessment and alleviate any fears or anxiety – often people will naturally become confused or concerned about the motivations of such an assessment or worried about any hidden agenda.

Explain:

- what you are doing;
- the general decision at hand;
- why a decision is needed to be made; and,
- what gave you reason to doubt the person's capacity.

Sometimes what might also be helpful is emphasising that the overall aim is to support people to make their own decisions– and achieve what they want – whilst ensuring that they have carefully thought through their situation and decision. A helpful, overall aim, could be to try and keep people in control of their own life whilst remaining **happy** and **safe.**

As previously referred to, the test of mental capacity has three elements:
a. An inability to undertake the decision making process (functional test)
b. An impaired of, or a disturbance in, the functioning of the brain or mind (diagnostic test)
c. The inability is because of the impairment or disturbance in, the functioning of the brain or mind (causation test)

The guidance will now explore these in more detail.

A. Inability (functional test)

This part of the test of capacity is broken down into four elements:

Assessing the ability to **understand** the information relevant to the decision.

Assessing the ability to **retain** the information relevant to the decision.

Assessing the ability to **weigh and use** the information relevant to the decision.

Assessing the ability to **communicate** a decision (by any means possible).

Assessing the ability to **understand** the information relevant to the decision.

Reflect on whether the person has a sufficient level of understanding. *T*he person would not necessarily need to understand everything about their whole situation, and all the peripheral details of the decision at hand, as this might set the bar too high – just the 'salient factors.'[14]

This is especially important when considering more complex decisions – for example, medical or significant financial decisions – when the expectation on the general population would be that they only need to have a broad and general 'layman's' understanding of the matters at hand, relying upon other professionals and experts for advice and guidance as appropriate.

Assessing the ability to **retain** the information relevant to the decision.

Reflect on whether the person has a sufficient level of memory or retention of information in regards to the decision at hand. However, as with the understanding element, this requirement need only apply to the 'salient factors' – the person should not necessarily be expected or required to remember every minute detail. Likewise, the person being assessed should only be required to remember the information long enough to make the actual decision or carry out the required action.

> ***The Act specifies at s.3(3) that: 'the fact that a person is able to retain the information relevant to a decision for a short period only does not prevent him from being regarded as able to make the decision.'***

This is about having the ability to retain the relevant information long enough to process it. Giving information in small pieces, and then asking them to repeat it back is, obviously, one way of assessing retention of the relevant information. The assessor could then, perhaps, also add another element and ask them to recall both parts / considerations. Having a discussion about the decision, and then, asking them to explain the situation in their own words can also be helpful. Consider using memory aids like written notes, pictures or technology like tablet computers.

[14] *LBJ v RYJ* [2010] EWHC 2664 (Fam).

Assessing their ability to weigh and use the information relevant to the decision.

Reflect on whether the person is able to **weigh** and **use** the information in order to arrive at a decision. Often this part of the functional test can cause assessors most uncertainty.

> ***This aspect of the test has been described as "the capacity actually to engage in the decision-making process itself and to be able to see the various parts of the argument and to relate the one to another."[15]***

Weigh

Firstly, it is about the person being able to consider, in their own mind, the various parts of the decision and decide the weight of importance or priority to give them relative to one another. This is essentially a value judgement made by the individual – what is important to them, and, conversely, what is not important to them - in their situation and life.

What aspects of the decision, or potential outcomes, do they give most value or priority to over others? This is where person-centred planning tools may prove useful in exploring what is or is not important, what makes them happy and safe, what do they want to achieve in their situation or, conversely, what they want to avoid.

This is about how the person sees the world and their life. It is about the person applying their own value system to the decision at hand and inevitably demands that the assessor seeks to explore, as far as possible, the person's values or altitudes to such matters in a person-centred way; seeking to see the situation and options from their perspective.

The difference between an unwise decision, and an incapacitated decision, is often involving this aspect of the capacity test.

In a judgment about medical treatment[16], J MacDonald said, at paragraph 38:

> ***'…a person cannot be considered to be unable to use and weigh information simply on the basis that he or she has***

[15] *The PCT v P, AH & the Local Authority* [2009] EW Misc 10 (COP).
[16] King's College Hospital NHS Foundation Trust v C [2015] EWCOP 80, [2015] MHLO 125

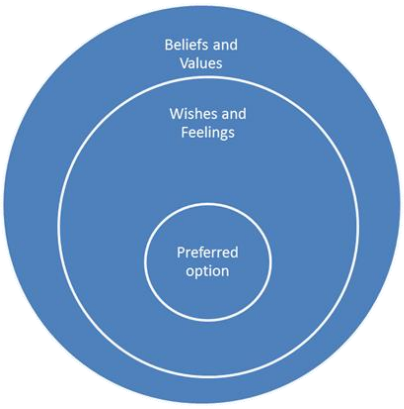
applied his or her own values or outlook to that information in making the decision in question and chosen to attach no weight to that information in the decision making process.'

Use

The ability to use information is about the person's ability to apply the information relevant to the decision – along with their own value judgements and what is or is not important to them - when making their decision or carrying out the action.

This involves considering how the person has weighed up the various parts of the decision, from their own value base, and looking to see if they have used this in making the eventual decision.

Where a person is expressing a clear preference, or carrying out a particular action, it might be helpful to consider whether there is a correlation with the person's expressed wishes/intent as well as their known beliefs and values.



Usually a person's wishes and feelings stem from their own personal beliefs and values. Where a decision or action(s) seems not to match with the person's own wishes and feelings, beliefs and values perhaps further investigation is required. If, for example, a person is saying one thing, but evidence shows they are doing another, it may be important to question whether the individual's impairment or disturbance has interfered with their executive brain function – ability to monitor and control their behaviours. A person may understand, retain and weigh information during a discussion but be unable to actually use this information in the moment the decision is required to be actioned.

There are two examples cited in the Mental Capacity Act 2005 Code of Practice (para 4.22):

- a person with the eating disorder anorexia nervosa may understand information about the consequences of not eating. But their compulsion not to eat might be too strong for them to ignore.

- a person with a serious brain damage might make impulsive decisions regardless of information they have been given or their understanding of it.

Please consider the tool at appendix 4 that may assist in considering how a person's wishes, feelings, beliefs and values support or conflict with various options. This can be used to consider within the assessment of capacity process or during any subsequent best interests decision-making.

Assessing the ability to communicate a decision (by any means possible) on the decision

The Act includes the term 'talking, using sign language or any other means' when referring to assessing whether the person can communicate a decision. It is essential that, where there are difficulties, all practical steps are taken to assist the person to communicate by any means. Consider how the person usually communicates and seek to reproduce this as best as possible. Try speaking with family members, friends, carers, etc., who know the person well, and look at how they communicate with the person.

The threshold for this should be low. The guidance from 39 Essex Street states that 'any residual ability to communicate is enough, so long as P can make themselves understood.'

The Mental Capacity Act 2005 Code of Practice provides suggestions, at paragraph 3.10 and 3.11, which include: '*use simple language. Where appropriate, use pictures, objects or illustrations to demonstrate ideas.*'

B. Impairment of, or a disturbance in, the functioning of the brain or mind (diagnostic test)

This is a very broad and inclusive statement. This does not require a formal diagnosis or need to be a mental disorder, within the meaning of the Mental Health Act 1983. The Code of Practice does however use the term 'requires proof,' at paragraph 4.11, when referring to this part of the capacity test. Nevertheless, in practice, this might be evidence obtained through observations and interactions with the individual as opposed to a clinical / medical diagnosis.

This requires broad thinking, and the Code of Practice provides examples at paragraph 4.12:

- conditions associated with some forms of mental illness
- dementia
- significant learning disabilities
- the long-term effects of brain damage
- physical or medical conditions that cause confusion, drowsiness or
- loss of consciousness
- delirium
- concussion following a head injury, and
- the symptoms of alcohol or drug use.

If a person does not have such an impairment or disturbance of the mind or brain, they will not lack capacity under the Mental Capacity Act.

C. Because of the impairment or disturbance in, the functioning of the brain or mind (causation test).

Crucially, within the definition of lacking mental capacity, there is a causation link required between the inability to make the decision (functional test) and the impairment or disturbance (diagnostic test).

Section 2(1) of the Act states:

"For the purposes of this Act, 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 brain.' (emphasis added)

It is vital not to overlook the requirement for any inability to make a decision to be "because of" an impairment or disturbance in the functioning of mind or brain. There needs to be a direct link made, it is all part of the same test of capacity.

Additional considerations regarding completing an assessment of capacity.

The threshold: 'reasonable belief'

The threshold for determining whether a person does or does not have mental capacity is 'reasonable belief' that the person does or does not lack mental capacity – it is on the 'balance of probabilities', more likely than not. It is not about having to be 100% sure or certain, rather, about a professional judgement taking account of the facts as they are presented and should be based upon the evidence obtained.

Focus on the *process* the person is able/unable to go through in making a decision as opposed to any actual decision itself.

The focus should be on the process a person is able or unable to go through - in arriving at a particular decision – not the eventual decision or outcome that they have arrived at. A person has the right to make an unwise decision and through focusing on scrutinising the decision making process as opposed to any particular outcome they are choosing, this right can be upheld.

The aim: Supported decision-making; not hijacked decision-making.

The initial focus must be on supporting people to make their own decisions and overcoming any barriers they have in this regard.

Be guarded against clouding objectivity through the desire to protect.

Assessments of capacity must not be unduly influenced by the 'protection imperative'[17]; that is, the perceived need to protect the vulnerable adult at all cost. There is a need to remain "detached and objective" in assessments - not skewing the assessments of capacity because of concerns for the risks posed to the individual, no matter how understandable they may be.

Not setting the bar too high!

It is not always necessary for a person to comprehend all peripheral details of their situation or options, we should not expect more from people with impairments that

[17] ***CC v KK & STCC [2012] EWHC 2136 (COP)***

we do of others in the wider population. The level of understanding required must not be set too high[18]

Take account of people's individual value judgements and normal responses to difficult decisions.

Different individuals may give different weight to different factors; this does not mean a person lacks mental capacity. An individual may decide to give no weight of importance to an aspect of a decision that another person may choose to prioritise. This is about people applying their own value judgements to decisions and outcomes.

Similarly, some individuals may be indecisive to avoid aspects of the decision or the decision as a whole, this does not necessarily mean the person lacks mental capacity.

Crucially, with both these points, the question is, can the lack of weight given to an aspect of a decision, indecisiveness or avoidance, be attributed to – '*because of*' – the impairment or disturbance or is this simply a normal human reaction to what might be a difficult or emotive decision.

> ***'…It must also be remembered that common strategies for dealing with unpalatable dilemmas – for example indecision, avoidance or vacillation – are not to be confused with incapacity. We should not ask more of people whose capacity is questioned than of those whose capacity is undoubted."***[19]

2.3 (4) Recording assessments of mental capacity

Section 4.10 of the MCA Code of Practice states:

> *'Anybody who claims that an individual lacks capacity should be able to provide proof. They need to be able to show, on the balance of probabilities, that the individual lacks capacity to make a particular decision, at the time it*

[18] *PH and A Local Authority v Z Limited & R* [2011] EWHC 1704 (Fam).

[19] Heart of England NHS Foundation Trust v JB [2014] EWHC 342 (COP) [26]

needs to be made (section 2(4)). This means being able to show that it is more likely than not that the person lacks capacity to make the decision in question.'

The level of detail should be directly related to the seriousness of the decision in question. For complex decisions, or those that have potentially serious consequences, it is advisable that the record should include direct references to what was **actually said by the assessor and the actual answers given by the individual**. This can either be within the assessment document or as a separate transcript that is referred to within the assessment form, either way, referring to the precise words or observations is often invaluable.



It is important not to simply make broad and generic statements that could apply to anyone. In documenting the assessment the assessor should refer to what was actually said and / or observed that led the assessor to come to a certain determination. The documentation must stand up in court, which means that it should show the 'workings out' i.e. what led the assessor to come to a particular determination.

Regardless of the forms that are being used, consider the requirements in the statute, Code of Practice and case law. The use of supporting documents – such as any person-centred planning tools – should also be submitted and referenced. They will help to describe how the professional decision was reached

Central Bedfordshire Council has a Mental Capacity Assessment/Best Interests Decision Form which can be used to record any formal assessment of mental capacity. Please see appendix 5.

POINT for REFLECTION:

Consider how evidenced-based your capacity assessments are; directly referring to what was said, observed and or reported by others, when making a decision on a person's capacity.

Part 3.

Best Interests decision: What is it? When to Assess? How to Assess?

3.1 Best Interests decision: What is it?

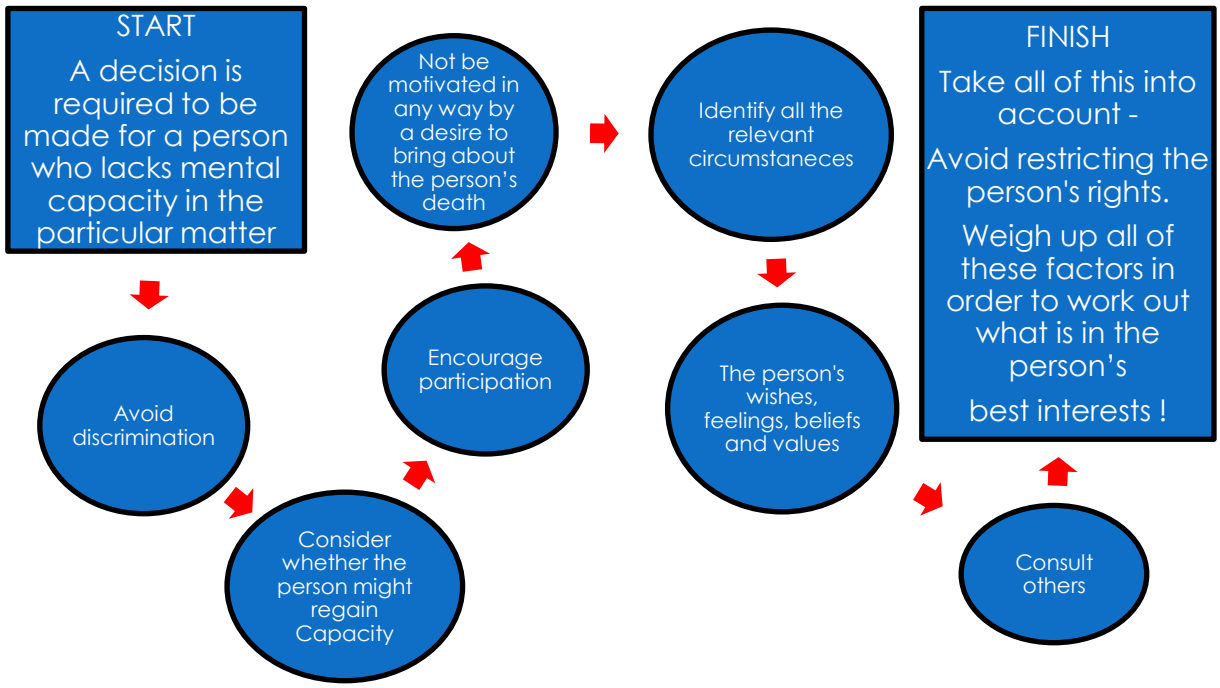
A best interests decision, under the meaning of the Mental Capacity Act 2005, is a decision made on behalf of a person lacking mental capacity at the time the decision is needed

It only applies once a person has received all support and assistance to make their own decision and, despite such support, they have been assessed to lack mental capacity in that particular matter (see part 2 of this practice guidance).

It is through this process of decision making that protection from liability, section 5 of the Act, is provided and allows 'decision makers' to carry out actions or make decisions for another person (for example, relating to care and support needs) where their valid consent is not achievable.

A best interests decision is a process; not a particular outcome.

Section 4 process



In many situations, especially adult safeguarding, it may be tempting to identify a particular option that appears safer than the alternatives and start referring to this being 'in the person's best interests' simply by virtue of it quickly reducing or removing presenting risks. It is essential that the practitioner understands no matter how appealing this may be, unless they adhered to the requirements in section 4 of the act this is not a MCA 2005 best interests decision.

A best interests decision is a process; not a particular meeting.

There are times when a formal best interests meeting may prove helpful, to ensure that all involved parties have the required information and facilitate open discussion, however, this is not a statutory requirement and in practice there are often times when the decision maker may require time for reflection outside of the meeting environment in order to carefully consider all the information and circumstances. Removing the expectation of a decision being made there and then, can often take the heat out of discussions allowing for a more fruitful meeting. It may not be possible to please everyone, and sometimes the decision-maker may require space to consider all the competing elements and views in order to come to a balanced decision focused on the individual.

The overall aim of a best interests decision was articulated in a Supreme Court judgement, involving a medical decision, when Lady Hale emphasised the importance of:

> ***Considering 'matters from the patient's point of view' and make the right decision for 'an individual human being.'***[20]

[20] Aintree University Hospitals NHS Foundation Trust v James [2013] UKSC 67

3.2 Best Interests decision: When to Assess?

A best interests decision can only be made when:

a) there is a concrete decision required to be made,

b) the person has been given all practical help and assistance to make their own decision, and

c) despite having assistance they have been assessed to lack mental capacity to make the specific decision at the time it is required.

> ***The first question a practitioner should ask: does a decision actually need to be made or can it be put off until the person regains capacity or improves?***

The term lacking mental capacity does not apply to an individual's understanding of abstract concepts or their circumstances – e.g. understanding their care needs. It should only be applied to assessing an individual's ability to decide between available and realistic options. A Mental Capacity assessment only comes into play when there is an actual decision – options to choose between.

It is also vital that before a best interests decision is considered, the practitioner is clear that there is no-one else with the legal rights and responsibility to make the decision in question – i.e. where there is an applicable and registered enduring power of attorney (EPA), lasting power of attorney (LPA) or court appointed deputy (please see part 1.3 of this guidance).

It is also good practice to support any attorney or deputy in making the best interests decision, supporting them through the decision making process; but, crucially, it is their decision to make. It is also advisable to obtain evidence of any LPA or Deputyship Order and, where there are concerns, legal guidance can be sought. The OPG100 form is available from the Office of the Public Guardian (OPG) website[21] which can be used to ask whether and EPA, LPA or deputyship order is registered.

[21] https://www.gov.uk/find-someones-attorney-or-deputy

3.3 Best Interests decision: How to Assess?

The process of making a best interests decision is commonly referred to as the best interests 'check list' within the code of practice and comes from section 4 of the Act. This section of the Act contains a list of factors that must, if applicable, be taken into account when making a best interests decision.
For assistance in application, the checklist has been expanded on below to incorporate wider steps that are best practice in making a best interests decision. The checklist has been separated into either considerations and requirements, or types and sources of information [22]

The best interests decision-making process can be summarised by the following six stages:

1. Define the decision and purpose
2. Follow s.4 of the MCA 2005
3. Consider the options in a 'balance sheet' approach
4. Consider the least restrictive way of achieving the desired outcome.
5. Make and record the decision
6. Risk reduction and contingency planning

3.3 (1) Step 1. Define the decision and purpose for which it is needed.

Ensure the decision has been defined correctly; including all the options available and the purpose. The decision is not an abstract question, rather the actual options available to the individual at the time the decision is required.
Frame the decision in a way that is objective and inclusive of all the available and realistic options. Instead of it being about consenting to one particular option, such as consenting to residential care, the decision should be phrased much wider; incorporating all the available options including those that may not be preferable to the professionals involved. For example:

[22] This part of the practice guidance draws on chapter 7 of 'Mental Capacity Act and Adult Safeguarding' Baker, D (2017) Safeguarding Adults Under the Care Act 2014 (understanding Good Practice), edited by Cooper, A. and White, E.

- No support at all
- Receiving care and support from family/friends only (if this is what they are offering)
- Remaining at home with the current level of care and support [describe what that is, including both professional and family support and any equipment or services being offered]
- Remaining at home with increased care and support [describe what that is, including both professional and family support and any equipment or services being offered]
- Remaining at home with a live-in carer [describe what that is, including both professional and family support and any equipment or services being offered]
- Moving into new accommodation, supported housing [describe what that is, including both professional and family support and any equipment or services being offered]
- Move into residential care [describe what that is, including both professional and family support and any equipment or services being offered]

3.3 (2) Step 2. Follow section 4 check-list

Section 4 is the process that, if followed correctly, enables the practitioner to refer to their eventual decision as made in the person's best interests and protects them from liability. For assistance in application, the checklist has been separated into either considerations and requirements or types and sources of information, as follows:

Overarching considerations and requirements – that must be applied.	**Types and Sources of information - that should be taken into account.**
Avoid discrimination (based on s4[1]) Practitioners should ask themselves: Have I included all the options available; without limiting them because of the person's age, appearance, condition or behaviour? Am I starting off with preferences or biases because of the person's age, appearance, condition or behaviour?	**Identify and consider all the relevant circumstances.** The decision maker must consider 'all the relevant circumstances' of the situation and decision in question (4[2] of the act). This includes 'all relevant factors that it would be reasonable to consider, not just those that they think are important…" (Code of practice, paragraph 5.7).

Are they expected to improve, and, can the decision be delayed? Practitioners should ask themselves: Is there a chance the person can make their own decision at a later date/time? If so, can and should the decision be delayed? Is there reason to expect the person's ability to improve in the future and, if so, why the decision cannot wait?	**The wishes, feelings, beliefs and values of the individual.** At the centre of every best interests decision must be the individual's past and present: wishes, feelings, beliefs, and values.
The decision maker must permit and encourage the individual to participate (based on s4[4]). Practitioners should ask themselves: How best to engage the person? Can I use some of the tools or guidance discussed in part 1? How do I ensure the individual is an active participant in the decision-making process?	**The views of other people.** The decision maker must take into account, if practicable and appropriate, the views of other people.
Consider the motivation (based on 4[5]). The decision must not be motivated by a desire to bring about the individual's death.	

3.3 (2a) Types and Sources of information: explored in more detail

Identify and consider all the relevant circumstances

In practice the 'relevant circumstances' are likely to be a mixture of:

- **Situation specific factors** – e.g. the individual's circumstances, relationship dynamics, care and support needs and options available.
- **Universal interests or rights** –e.g. European Convention of Human Rights and concepts outlined in the Care Act 2014 definition of Wellbeing (s1[2]).

It is worth considering relevant circumstances from both these two perspectives.

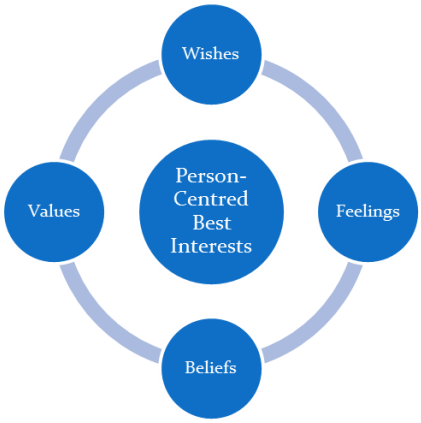
Take a holistic general welfare approach; looking at the person and their situation as a whole, not just personal safety. This will inevitably include matters, such as, the importance of:

- **Emotional welfare** (Re A [medical treatment: male sterilisation] [2000] 1 FCR 193),

- **Relationships and belonging** (FP v GM and A Health Board [2011] EWHC 2778 [21])
- **Happiness** (Re MM (an adult) [2007] EWHC 2003 (Fam).

The wishes, feelings, beliefs and values of the individual.

In the same way that the supported decision-making approach does not stop at the point an assessment of capacity is considered as required it should also continue into any subsequent best interests decision making process. At this stage, however, it moves from trying to enable the person to make their own decision – exercising their own rights to legal capacity – and moves into **trying to enable the person to direct and influence, as much as possible, any subsequent decisions made on their behalf.**



The courts have given increasing weight of importance to the wishes, feelings, beliefs and values of the individual in question – placing such matters at the centre of the best interests decision making process, Although, at present, there is no default hierarchy, amongst the elements listed in s.4, the future direction of MCA amendments is to give 'particular weight'[23] to any ascertainable wishes and feelings, beliefs and values of a person. It is therefore advisable to ensure that any current best interests decision should also have these at its heart;, by explicitly evidencing how the decision maker identified such matters and sought to achieve what is, or likely to be, important to the person.

> ***'There is little purpose in safeguarding an individual if the outcome does not achieve what is important to them.'***[24]

[23] See https://www.lawcom.gov.uk/project/mental-capacity-and-deprivation-of-liberty/

[24] Page 138, chapter 7 'Mental Capacity Act and Adult Safeguarding' Baker, D (2017) Safeguarding Adults Under the Care Act 2014 (understanding Good Practice) edited by Cooper, A. and White, E.

This means that practitioners must see the uniqueness of every individual, with their own values, likes and dislikes, and to consider their best interests in a person-centred way. Seeing the situation and options through the eyes of the individual, their own value base and trying to take account of the individual's 'own assessment of the quality of their life' is vital.[25]

Munby J in the case of Re M, ITW v Z, M and Others [2009], at para 35, affirmed that the individual's wishes and feelings 'will always be a significant factor' but that the weight to be attached 'will always be case-specific and fact-specific'. Munby J also provided pragmatic guidance when considering the weight on a case by case basis. This includes considering aspects like:

- the **degree of the incapacity**
- the **strength and consistency of the views** being expressed.
- the **possible impact on P** of their wishes and feelings not being actioned/allowed
- the extent to which P's wishes and feelings are, or are not,
    - **rational,**
    - **sensible**,
    - **responsible,** and,
    - pragmatically **capable of implementation**
- the extent to which P's wishes and feelings can properly be accommodated within the overall assessment of **what is in their best interests**.

As this guidance emphasised previously, the primary objective is to ensure that the person remains in the driving seat of their life and discourages others from inappropriately taking over the controls: ***Supported decision making; not hijacked decision making*.**

Any person centred planning tool, previously completed to maximise the person's ability to make their own decisions, is likely to be highly relevant here and should be used to inform any eventual best interest's decisions.

Please consider again the tools at appendices 2 and 4 to assist exploring what is important to a person in their situation or current decision.

[25] Re M(best interests: deprivation of liberty) [2013]EWHC3456 (cop)[38]

The views of other people

The decision maker must take into account, if practicable and appropriate, the views of other people. This includes anyone:

- named by the individual
- engaged in caring for them
- interested in their welfare
- donee of a lasting power of attorney granted by the person, or,
- deputy appointed for the person by the court

This is a very broad range of people and therefore should not be reduced to speaking with the one person whom appears closest to the individual. Such people may have known the individual all, or most, of their life, often prior to them losing mental capacity. Their insights may be invaluable in terms of glimpsing who the person is, especially when the individual can no longer express their own views and preferences.

In this aspect of best interests decision making, the practitioner must ensure that they do not confuse the interests of others with the best interests of the individual in question. There may be occasions when these are virtually inseparable but the focus must remain on the individual and what is in *their* best interests.

Practical suggestion - start by asking the person being consulted about the individual:

- what were/are *their* interests,
- what is/was important to *them*,
- what informed previous similar decisions *they* made,
- what would be the *individual's* views and opinions /attitude on such matters.

Having initially framed the consultation from this person-centred perspective, the practitioner can then move onto asking those being consulted about their own personal views on the matter.

The practitioner must also remember that, in different circumstances, an advocate (known as an Independent Mental Capacity Advocate [IMCA]) may be required to contribute towards important decisions; namely, serious medical treatment, changes of accommodation, adult safeguarding decisions or care reviews. Chapter 10, in the MCA 2005 Code of Practice, covers these requirements but please use the following as a summary:

An IMCA **must** be instructed **if the individual has nobody else** who is willing and able to represent them, or be consulted in the process of working out their best interests, in relation to decisions of:

- Serious medical treatment
- Accommodation in hospital for longer than 28 days
- Accommodation in the care home for more than 8 weeks

An IMCA **may** be instructed in relation to decisions of:

- **Care reviews -** if the individual has nobody else who is willing and able to represent them, or be consulted in the process of working out their best interests.
- **Adult Safeguarding Situations** – regardless of whether or not family, friends or others are involved.

IMCA and Adult Safeguarding: three requirements.
It has been considered to be of 'particular benefit' to the individual
The person has been assessed as lacking mental capacity to make decisions relating to one or more 'protection measures'
One of the following factors is also present **i.** a **serious exposure to risk** risk of death; risk of serious physical injury or illness; risk of serious deterioration in physical or mental health; risk of serious emotional distress **ii.** a **life changing decision** consulting family or friends is compromised by the reasonable belief that they would not have the person's best interest at heart. iii. there is **a conflict of the views between the decision-makers** regarding the best interests of the person. iv. **a risk of financial abuse** which could have a serious impact on the welfare of the person.

For more information, advice and support, contact PoHWER on 0300 456 2364 or email pohwer@pohwer.net.

It is worth reiterating again here, as it is so important, that any Power of Attorney or Deputy must be consulted and, where it is within their legal authority, they are the decision maker (S4[7] of the Act).

There have been many cases where the exclusion of close friends and family were heavily criticised by the courts. By way of examples the cases of Milton Keynes Council v RR and Ors [2014] EWCOP B19 and Somerset v MK (Deprivation of Liberty: Best Interests Decisions: Conduct of a Local Authority) [2014] EWCOP B25 are worthy of consideration.

3.3 (3) Step 3. 'Balance sheet' approach.

Once the decision maker has applied the above Section 4 process they should 'weigh up all these factors in order to work out what is in the person's best interests' (The MCA code of practice, chapter 5, page 66). The recommended method for this process of weighing up all the factors is the 'balance sheet' approach, first identified by Thorpe LJ in Re A [2000] 1 FLR 549 at 560.



The process can be broken down into the following stages:

1. Listing all the identified options available. It should include any options identified by the individual themselves or others involved. If particular options are not included the reason for this should be clearly recorded. The option of making no decision at all, or refusing all choices, may also be relevant.

2. Entering the influencing factors - such as those identified through following section 4 of the Act - against each option, **either as a benefit or disadvantage to the individual.**
3. Consider the weight of importance to be attached to each benefit or burden influencing factors.

NB: Alex Ruck-Keen at al (2015) explain that when considering the weight to attach to various factors it is important to set out with reasons:
(1) The **risks and benefits** to the individual
(2) The **likelihood** of those risk and benefits occurring
(3) The relative **seriousness and/or importance** of the risk and benefits to the individual

It is important to consider whether there are any factors considered to have 'magnetic importance' capable of overriding all other considerations[26] and, if so, explain why this is considered so influential.

In many situations this balancing act often means trying to find the option which represents maximum benefit to the person's happiness and safety, with minimal negative impact upon the individual and their rights. In other words, the decision maker is aiming to identify the option with the most acceptable burdens/ risks in order to secure some identified greater good for the individual.

Munby J articulated this well:

> ***'sensible risk appraisal, not striving to avoid all risk, whatever the price, being willing to tolerate manageable or acceptable risks as the price appropriately to be paid [...]to achieve the vital good of the elderly or vulnerable person's happiness.' [27]***

[26] Re M, ITW v Z, M and Others [2009] EWHC 2525 (Fam)
[27] Local Authority X v MM (by the official solicitor) and KM [2007] EWHC 2003 (fam)

Options that might at first sight appear clearly unfavourable must also be considered and recorded, even if only to later be ruled out.

Please consider the tools at appendix 6 that may assist in considering different relevant factors, views and opinions, upon a best interests decision. It also allows for the practitioner/decision-maker to consider the level of importance (weight) for each aspect. This may be helpful before entering relevant factors onto a balance-sheet to focus on each element separately. There is also an example of a completed balance-sheet taken from ADASS guidance relating to Deprivation of Liberty.

3.3 (4) Step 4. Can the desired outcome be achieved in a way that is less restrictive?



Best interest decisions are not an 'off-switch' for the rights and freedoms of the individual (Wye Valley NHS Trust v Mr B [2015] EWCOP 60 [11]). As far as possible, basic human rights must be upheld; which should be the same for everyone regardless of condition or disability.

The decision maker must consider any lesser restrictive alternatives that would also achieve the desired purpose - this is to comply with the fifth principle of the MCA 2005.

This does not mean that the decision maker is obliged to always choose the option which is least restrictive, if this is not also in the person's best interests, but it does require them to always consider the lesser restrictive options and record why they are not appropriate. . The Code of Practice states '…the final decision must always allow the original purpose of the decision or act to be achieved' (Para 2.15, page 27).

It is absolutely crucial that where a particular course of action or potential decision may engage a fundamental right or freedom, such as a person right to liberty (article 8 ECHR) or private and family life (article 5 ECHR), the practitioner seeks legal advice. Depending upon the circumstances, authorisation may be required

from the Court of Protection or the Deprivation of Liberty Safeguards; and, there should be a record of how the practitioner has attempted to avoid this eventuality.

*The right to **life;** The prohibition of **torture** and **inhuman treatment**; Protection against **slavery** and **forced labour**: The right to **liberty** and **freedom**; The right to a **fair trial** and **no punishment without law;** Respect for **privacy** and **family life** and the right to **marry**; Freedom of **thought**, **religion** and **belief**; Free **speech** and **peaceful protest**; **No discrimination**: everyone's rights are equal; Protection of **property**; The right to an **education**; The right to **free elections***



3.3 (5) Step 5. Make and record the decision.

The practitioner is required to come to a decision, having followed the above process, as to what they 'reasonably' believe to be in the best interests of the individual (Section 4 [9]). It is not about being 100% sure, or that the chosen decision has absolutely no disadvantages. It is about a fair and objective process where matters are considered on the 'balance of probability' and the correct process has been followed and recorded.

It is good practice to set out a conclusion. This should clearly state why the decision was needed to be made, how the individual was able and encouraged to contribute, the eventual decision, the reasons for not selecting any available lesser restrictive options, and, if applicable, any disagreements between those consulted and the decision maker.

Detailed record keeping of the decision is particularly important where there is a dispute or the chosen option has significant disadvantages to the individual. For example, distress to the individual, loss of independence or difficulties in sustaining important relationships.

The Code of Practice provides guidance on resolving disputes – such as mediation, second opinions and complaints processes – but advises "ultimately, if all other attempts to resolve the dispute have failed, the court might need to decide what is in the person's best interests" (paragraph 5.68).

3.3 (6) Step 6 Risk reduction and contingency planning.

Once a best interests decision has been arrived at, consider any remaining risks or perceived disadvantages. The reasons why any concerns or risks are thought to be outweighed by the perceived benefits must be recorded. This should lead to creating a plan, with the individual where possible, exploring what could be done to monitor, reduce or mitigate such risks or disadvantages further.

Central Bedfordshire Council has a Mental Capacity Assessment/Best Interests Decision Form which can be used to record any formal assessment of mental capacity. Please see appendix 5.

Appendix 1

Tool for recording the information provided to an individual about a particular decision.

(Insert the Decision: e.g. what level of home care to receive (if any) from the options being offered of X, Y and Z)				
List options available.	Consider what information is required? (including, likely foreseeable consequences of this option)	When is this information required?	Who is best placed to provide this information?	How should this information be communicated and explained?

Appendix 2

Tools exploring what is important to someone about their situation. Consider these for inspiration and feel free to be creative. Remember, what works for one, may not be appropriate for another.

The person's crrent decision/actions/outcome is...

Insert the Decision: e.g. where to live and receive care and support with my assessed needs.

Explore with the individual the following points in relation to the choices they are currently making:

I want the above because...

In relation to the above *I would like....*

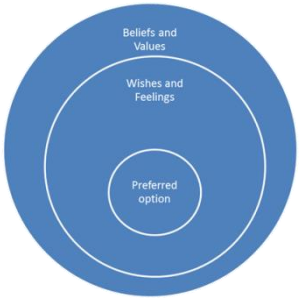
In relation to the above *I feel that...*

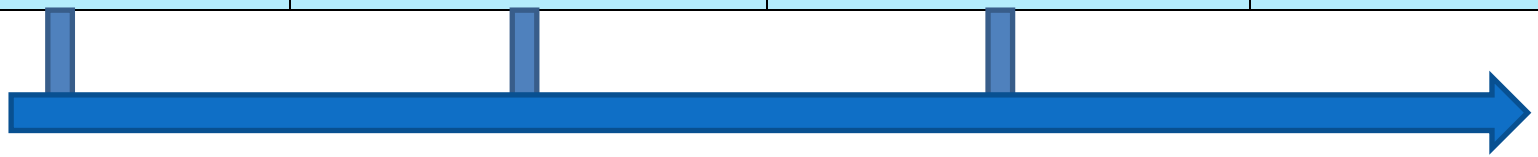
In relation to the above *I believe that...*

In relation to the above *I value....*

Appendix 2(b)

Wishes, Feelings, Beliefs and Values.



Values	Beliefs	Feelings	Wishes
			
What is important to the person – notions of good and bad, right and wrong? -general principles-	What the person thinks to be true.	Emotional reaction or state about something.	Expressed preferences/ desired objective or outcomes.
For example: Marriage is important to me	For example: A husband/wife should live together.	For example: I feel lonely without my husband/wife.	For example: I want to remain living at home with my husband/wife. .

Appendix 2(c)


What makes me happy?
What makes me safe?
Where am I most happy?
Where am I most safe?
When am I most happy?
When am I most safe?
Who makes me happy?
Who makes me safe?

Appendix 3

Tool that may be used to consider each aspect of the test of capacity and how to maximise the person's abilities.

How does the person's impairment of, or a disturbance in the functioning of, the mind or brain impact their ability to make decisions?	What practical actions or steps might **reduce, remove or overcome these difficulties** during the assessment?	Actions taken to promote decision making ability.
e.g. P becomes agitated in the evening; poor short-term memory, acts without inhabitations.		
What difficulties does the person have in understanding information? .	What practical action or steps can I take that will **assist the person in understanding** their situation or options better during their assessment?	Actions taken to promote decision making ability.
e.g. P can get confused with too much information; does not read, finds abstract concepts difficult		
What difficulties does the person have in retaining information?	What practical action or steps can I take that will **assist the person in retaining the relevant information** for just long enough to make the decision during the assessment?	Actions taken to promote decision making ability.
e.g. P will often forget what is being discussed,		
What difficulties does the person have in using or weighing information?	What practical action or steps can I take that will **assist the person in weighing or using the relevant information** during the assessment (comparing and contrasting options, or seeing how they may relate to one another)?	Actions taken to promote decision making ability.
e.g. spontaneous actions due to reduced inhabitations.		
What difficulties does the person have in communicating information?	What practical action or steps can I take that will **assist the person in communicating** their decision?	Actions taken to promote decision making ability.
e.g. Does not verbalise,		

Additional notes for Appendix 3

1. **What practical actions or steps can be taken that will minimise or eliminate the effect of the person's impairment or disturbance during the assessment?**

    - Can any short-term impairments be addressed – e.g. infections treated?
    - Has any prescribed medication been taken that improves cognitive functioning and or sufficient time left after such medication taken?
    - Are their certain times of the day when a person's cognitive abilities are better or worse?

2. **What practical action or steps can be taken that will assist the person in understanding their situation or options better during their assessment?**

    - Are there any tangible or physical items that can assist? Perhaps showing the individual relevant items, locations or people, etc that the decision involves.
    - Are there examples from the person's own past that may help them understand parts of the decision?

3. **What practical action or steps can be taken that will assist the person in retaining the relevant information for just long enough to make the decision during the assessment?**

    - Writing information down.
    - Having pictures at hand.
    - Having items laid out in front of the person.
    - Repeating just the fundamental points when needed.
    - Not requiring the person to remember nonessential information – just the salient points.

4. **What practical action or steps can be taken that will assist the person in weighing or using the relevant information during the assessment (comparing and contrasting options, or seeing how they may relate to one another)?**

    - Ask the person what they like/dislike about each option separately?
    - Try and explore why, from their perspective, they have considered certain elements of the decision more important than others.
    - What is the most important outcome to them and why?
    - Try and help them compare different parts of the decision or see how they might relate.
    - Are they drawing upon different parts of the decision at hand – if not, why not?

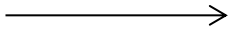
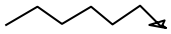
5. **What practical action or steps can be taken that will assist the person in communicating their decision?**

    - Any specialist assessments required, for example, Speech and Language Assessment
    - Communicational needs – including hearing
    - Reading? Writing? Verbal? Physical gestures? Facial expressions.

Appendix 4

Tool to assist in considering how a person's wishes, feelings, beliefs and values support or conflict with various options.
This can be used to consider within the assessment of capacity process or during any subsequent best interests decision-making.

Options	Draw connecting lines between what is or is not important to the person (wishes, feelings, beliefs and values).	What is important/is not important to the person... Wishes, feelings, beliefs and values	Reasoning for why this link has been made?

Draw a connecting line between the various identified wishes, feelings, beliefs and values and the various options – as with supporting or conflicting with one another. E.G Perceived as supporting this option =  OR Perceived as conflicting with this option = 
The practitioner could also increase boldness of the line to indicate particular weight or importance.

Appendix 5

Copy of Mental Capacity Assessment/Best Interests Decision Form.

BEDFORDSHIRE AND LUTON
MENTAL CAPACITY ACT
LOCAL IMPLEMENTATION NETWORK

DOCUMENTATION FOR THE MENTAL CAPACITY ACT 2005

ASSESSMENT OF CAPACITY

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STAGE THREE: Deciding on **when to instruct an Independent Mental Capacity Advocate**	**7**
STAGE FOUR: Best Interest Decision	**7-9**

SERVICE USER DETAILS

NAME OF PERSON	
DATE OF BIRTH	
MPI/SWIFT/CARE FIRST/NHS NUMBER	
ADDRESS	
MAIN CARER OR NEXT OF KIN	
NAME OF DECISION MAKER/ASSESSOR	
POSITION HELD	
TEAM	
NAMES, ROLES AND DETAILS OF OTHER PROFESSIONALS: (Include Advocates or Independent Visitors)	

DO ANY OF THE FOLLOWING APPLY?		**DETAILS:** including the date the document was drawn up, and when it was registered with the office of the public guardian
ENDURING POWER OF ATTORNEY (for property and affairs ONLY - created prior to the Mental Capacity Act, but still valid)	**YES / NO**	
LASTING POWER OF ATTORNEY (for property and affairs or personal welfare-replaced Enduring Power of Attorney following the implementation of the Mental Capacity Act)	**YES / NO**	
DEPUTY (someone appointed by the Court of Protection to make decisions on behalf of someone who lacks capacity to make the specific decision**.** Can be in relation to property and affairs, or personal welfare or both, must be stated on documentation.	**YES / NO**	
ADVANCE DECISION TO REFUSE TREATMENT (ADRT) Details specific treatments that the person wishes to refuse – must be valid and applicable to the situation	**YES / NO**	

DATE ASSESSMENT STARTED	

STAGE ONE ASSESSMENT OF CAPACITY

1. **DECISION**

Every adult should be assumed to have the capacity to make an informed decision; unless it is proved that they lack capacity. An assumption about someone's capacity cannot be made on the basis of a person's age, appearance, condition, or aspect of their behaviour.

1.1 **What is the specific issue/context requiring an assessment of capacity?**

Please specify the question this assessment of capacity is intended to answer. **NB. If more than one decision needs to be made, please use a new assessment form for each decision, only if capacity is in question.**			
Please tick the Issue/ Context this question arises from			
Change of Accommodation		Control of personal finances	
Providing, withholding or stopping serious medical treatment		Dispute between Local Authority or Trust staff relating to a persons care or treatment	
Giving Covert Medication		Recurrent unsafe behaviour	
Decision with clear legal aspect (Such as Court of Protection issues)		Safeguarding of Vulnerable Adults (SOVA) ** IMCA can still be instructed in SOVA cases even if the service user has family or friends' providing it has been established that the person lacks capacity and is evidenced on this form. The IMCA service will require a copy of this assessment.	
Restriction of Free movement (including restraint (MCA Code of Practice 6:39-6:52)		Other (please specify)	

NB. Any assessment of capacity must be related to a specific issue. Where there is more than one issue, more than one capacity assessment must be carried out.

1.2 **Is there an Impairment of or disturbance in the functioning of the person's mind or brain?**

(for example symptoms of alcohol or drug use, delirium, concussion, head injury, conditions associated with mental illness, dementia, significant learning disability, brain damage, confusion, drowsiness, or loss of consciousness due to a physical or medical condition)

Response	**Evidence/Comments and Source**
YES / NO	

If you have answered NO to STAGE ONE above, the person is considered not to lack Mental Capacity within the meaning of the Mental Capacity Act. You do not need to proceed any further. Please sign and date to conclude.

DATE ASSESSMENT COMPLETED	
SIGNATURE	

If you have answered YES to STAGE ONE, please proceed to STAGE TWO of the Assessment.

STAGE TWO ASSESSMENT OF CAPACITY

2. **ASSESSMENT**

2.1 **What is the extent of the person's impairment? Please tick as appropriate**

Permanent		**Temporary**		**Fluctuation**	

	Response	**Evidence/Comments and source**
Having determined that the person has an impairment, please confirm whether you have given **consideration to the ease, location and timing of the Capacity Assessment;**	**YES / NO**	
Please confirm whether you have given **consideration to the relevance of the information communicated; the communication method used; and other people's involvement in the Assessment**	**YES / NO**	
Please confirm whether you have given **consideration to the cultural influences, or social context that may affect the person's ability to make an informed choice?**	**YES / NO**	

2.2 **Please complete the following questions in order to form an opinion as to whether the impairment is sufficient to suggest that the person lacks the capacity to make the particular decision at this moment in time.**

	Response	**Evidence/comments and source**
Do you consider the person is **able to understand the information relevant to the decision?** and that this information has been provided in a way that the person is most likely able to understand?	**YES / NO**	
Do you consider the person is **able to retain the information for long enough** to be able to make the decision?	**YES / NO**	
Do you consider the person is **able to use or weigh that information** as part of the	**YES / NO**	

process of making the decision?		
Do you consider the person is **able to communicate their decision?**	**YES/ NO**	

If you have answered YES to the questions above, then on the balance of probability, the person is likely to have capacity to make this particular decision at this time. Conversely if you have answered NO to any of the questions then on the balance of probability the person is likely not to have capacity and you will be required to proceed to STAGE THREE

Please record a conclusion, sign and date this form and record the outcome within the Person's records.

	CONCLUSION
Do you think that the person <u>HAS the capacity to</u> make this informed Decision at this time? **Or** **Do you think that the person <u>does NOT have the capacity to</u> make this informed Decision at this time?** **Please give your reasons for your conclusion.**	
SIGNED	
DATE OF ASSESSMENT	

STAGE THREE	INDEPENDENT MENTAL CAPACITY ADVOCATE

Is there a known relative or friend to consult with?	**Yes ☐ No ☐**
Name	Contact Details
Where there are no relatives/friends to consult with, an Independent Mental Capacity Advocate (IMCA) must be instructed	
Name of IMCA	Contact Details
If the person is deemed to lack Mental Capacity for this decision at this time and has no-one to consult, you as a professional MUST instruct an IMCA. Call PoHWER for further advice**: 0300 456 2370**	

STAGE FOUR	BEST INTERESTS

When it has been established that the person does not have capacity to make their own decision, a decision must be taken in their best interests. Before **you complete the Best Interests Decision part in Stage Four, you must wait for a report from the IMCA and give consideration to the IMCA's findings, before making your final Best Interest Decision.**

Best Interest Process (please tick)		
Meeting ☐	Series of Separate Discussions ☐	Combination ☐
What is the likelihood of the person regaining Mental Capacity?		
Can the decision be put off until the person regains Mental Capacity? Yes ☐ No ☐		
What is the person's Preferences/Wishes?	**Source of Information**	
Record below how has the person been included in this decision?		

Names of People to be involved in the Decision (Including, where relevant the IMCA)	
Name	Title/Relationship
Brief Description of their views	
Views	Name

Complete a Benefits and Risk Section for each Option (including the option not to provide the intervention)	
Option 1	
Benefits to the individual of Proceeding	Risks to the Individual of Proceeding
Option 2	
Benefits to the individual of Proceeding	Risks to the Individual of Proceeding
Option 3	
Benefits to the individual of Proceeding	Risks to the Individual of Proceeding
Option 4	
Benefits to the individual of Proceeding	Risks to the Individual of Proceeding
Option 5	
Benefits to the individual of Proceeding	Risks to the Individual of Proceeding

Outcome of the Discussion/Meeting (including disagreements)
Attach meeting notes here.

REMINDER IF IMCA INVOLVED It is your responsibility as decision maker to inform the IMCA of the final Best Interests decision as soon as it is made.

Where the decision is to proceed, consider:

- How the individual is going to be prepared for the treatment/intervention
- How will the individual be supported after the treatment/intervention?
- Develop a separate plan

Will the decision be reviewed? Yes ☐ No ☐

Decision to be made?	When?	By Whom?

Declarations of the Decision Maker
I confirm that the following decision has been made without assumption as to the age, appearance, condition or behaviour of the person.
I confirm that where the decision relates to life sustaining treatment, I am satisfied that the decision made has not been motivated in any way, by a desire to bring about the person's death?
I confirm that I have considered all relevant factors. I have taken reasonable steps to establish whether the person lacks capacity in this matter. I reasonably believe that the person does lack capacity in relation to this matter and that it will be in the person's best interest for the decision to be made/act to be done.
Signature Date

Further declaration of Decision Maker
I confirm that where the decision/act is intended to restrain, I believe that the restraint used is necessary in order to prevent harm to the person and that it is a proportionate response to the likelihood and seriousness of that harm.
Signature Date

Appendix 6

Tools considering different relevant factors and their level of importance (weight). There is also an example of a completed balance-sheet taken from ADASS guidance.

RELEVANT FACTORS / VIEWS AND OPINIONS	RATIONALE OF THE LEVEL OF IMPORTANCE ATTRIBUTED TO THIS ELEMENT IN BALANCING THE DECISION ONE WAY OR ANOTHER.
1.)	
2.)	
3.)	
4.)	
5.)	
6.)	
7.)	
8.)	
9.)	
10.)	
11.)	
12.)	

Balance-sheet example adapted from ADASS deprivation of liberty guidance (Aug 2016)

This hypothetical scenario involves a woman in her 70s with bipolar affective disorder, vascular dementia and personality disorder who was being required to reside by her guardian in a nursing home, which she was also subject to a DOLS authorisation, but wanted to return to her own home. Using this tool is not about looking at which list has the 'most' factors; each factor will have a different weight. It may be worth considering using different fonts in the balance sheet to identify the different weight attached to the considerations. (For example **'bold'** indicates more than equal weight, and ***'bold and underlined'*** indicates particularly weighty considerations.)

BENEFITS OF CARE HOME (A)	**BENEFITS OF RETURNING HOME (B)**
1. Staff are able to facilitate regular contact with her son. 2. Encouraged to engage in leisure and social activities routinely with support. 3. Is able to attend local church, go shopping and see friends. 4. **Familiar environment where she has mostly resided for more than 1 year.** 5. **Mental health and associated symptoms can be effectively monitored and deterioration minimised.** 6. Accurate standardised and functional assessments can be offered and more effectively completed. 7. Readily available support to maintain self-care and activities of daily living. P will accept help with self-care in the nursing home, and in fact will demand it, whereas will refuse it at home. 8. Nursing home staff are able to manage her emotional responses to promote positive mental health and wellbeing. 9. **Staff are able to manage her diet, fluid intake and prescribed medication in respect of her physical ill health.** 10. Encouraged to use walking frame to maintain mobility and to minimise risk of falls. 11. Minimises risk of financial exploitation. 12. Friend now believes that she requires 24 hour support.	1. **Recognises her Article 8 right to respect for her home, private and family life.** 2. **This is where she feels most content and where she probably feels as though she belongs.** 3. During trial was observed as being able to use her mobility scooter safely. 4. She believes that she can cope at home. 5. Accepted breakfast being prepared by care team during trial. Friend indicates that she will eat if not eating alone. 6. Able to use local shops independently during trial to purchase fast food. Was supported by shop staff to put her purse away safely and to carry items to her scooter. 7. Was mostly able to manage her medication during trial. 8. During trial was able to wash her own clothes and attend to self-care, although care staff observed that personal care was not attended to.

PLUS BURDENS OF CARE HOME (A)	**PLUS BURDENS OF RETURNING HOME (B)**
13. **Reflects her clearly and consistently expressed wish is to return home.** 14. **Has previously indicated her dislike with the nursing home and that she felt like a prisoner.** 15. **Emotional and psychological distress caused by having her requests to return home overruled by her guardian.** 16 Proportionate restrictions are placed on her liberty in her best interests. 17. Risk of losing her home. 18. Not able to access the community without support. 19. Risk of losing her independence. 20. Risk of becoming deskilled. 21. Has on occasion been aggressive to other residents and staff.	9. Does not realise the risks to health and Safety. 10. **History of refusing to engage with assessments and community care services** (eg. declined occupational therapy assessment during trial). 11. **History of neglecting her diet** (eg. did not engage in meal preparation during trial. 12. History of overusing telephone. 13. Gets anxious in the community. 14. Likely to misuse her medication with consequent risks such as aggressive outbursts. 15. Was aggressive with friend during trial when she tried to assist with medication monitoring. 16. **Has previously been aggressive to care staff who have been unable to support her**. 17. GP has also previously voiced concerns over returning home, believing she should be in 24 hour care due to vulnerability and care needs. 18. Previously refusing medication and overusing A&E and GP, calling for ambulances inappropriately