

A Long Road to Travel:

The impact of the Mental Capacity Act
on Adults with Complex Needs in Residential Settings



Time to get equal

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About cerebral palsy.
For disabled people achieving equality.

Acknowledgements

This report was commissioned as a result of a successful Scope tender to the Department of Health to produce a study of the immediate impact of the Mental Capacity Act on adults with complex needs in residential settings.

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Foreword

by Sharon Collins, Managing Director of Services, Scope

The Mental Capacity Act 2005 (MCA) marked a major and welcome step forward in disabled people's rights. For the first time in UK history we have a legal framework through which to formally recognise and protect the fundamental rights of people who lack mental capacity to make their own decisions.

As an organisation whose mission is that disabled people achieve equality, Scope lobbied hard to shape and support the MCA. Now it is in place, we have turned our attention to ensuring that these new rights become a reality for the people who use our services. This research, funded by the Department of Health, looks at the impact the MCA has had, since its implementation, on a small number of individuals with limited mental capacity who use Scope's residential services.

Scope provides services to a large number of disabled people who have complex support needs. Scope is continually striving to improve the services we offer to disabled people and as many of our customers have limited mental capacity the MCA has particular relevance for us as an organisation. We are currently undertaking a major service transformation programme to ensure that we are able to deliver the range of personalised, responsive 21st Century services, that disabled people have told us they want. Supporting the principles enshrined in the MCA is a fundamental part of this work.

It was important to me that Scope took part in this research. Critically examining our own policies and practices is an essential part of improving the services we offer and helps to put us at the forefront of driving improvements in provision of services that support disabled people's independence.

Participating in this research project was an important learning experience for Scope but as the research shows, implementing the MCA in a residential setting is no easy feat. There are still many cultural and systemic barriers to overcome before we can be confident that the rights of every person who lacks capacity are being fully supported.

Changing culture and removing the legislative, policy and practice barriers will not happen overnight. It will take time and it will take leadership. The MCA provides the framework but we will need a joint effort from service providers, disabled people and policy-makers to really make these changes real. My colleagues and I at Scope are committed to delivering modern, world-class services that maximise disabled people's choice and control over their lives. I hope this research will encourage others to join us.

Sharon Collins, January 2009

Introduction

We all make choices everyday, some good, some not so good – but this is all part of the way in which we develop the skills to take more control of our own lives. For some people, making even everyday choices can be difficult if others do not support them.

At some point in our lives we are all likely to be affected by a lack of capacity to make decisions, either personally, or because someone close to us is unable to make decisions for themselves. Millions of people lose their ability to make decisions that affect their lives. This may be through illness, disability or injury. Some people are born with disabilities or conditions that affect their capacity to make decisions. Millions of people also have caring responsibilities for people who lack capacity.

The Mental Capacity Act 2005 (MCA) is intended to improve people's lives and came about because current common law lacked consistency and people's autonomy was not always respected. The Act states that everyone should be treated as able to make their own decisions until it is shown that they cannot. It also aims to enable people to make their own decisions for as long as they are capable of doing so.

The MCA puts the individual at the heart of the decision-making process, and places a strong emphasis on supporting and enabling people to make their own decisions or involving them as much as possible. The Act also aims to safeguard and protect those in society who may have a condition which leaves them with a lack of capacity to make some decisions for him or herself.

A person's capacity to make a decision should be established at the time that a decision needs to be made. A lack of capacity could be brought about because of a severe learning disability, dementia, mental health problems, a brain injury, stroke or unconsciousness due to a sudden accident.

The potential impact on the lives of many disabled people, especially those with complex impairments, should not be underestimated. This is particularly so for those who live in residential services where often a culture of risk aversion has grown sitting alongside a 'we know best' paternalism.

The Act makes the assumption that disabled people do have the capacity to make their own decisions, unless evidence can be produced to the contrary. An emphasis must be made here on the fact that it is the law – no ifs, no buts, nobody saying this does not apply to me or to this service. Professionals who work in health, social care and education, supporting adults who may be considered to lack capacity have a duty to comply with the Act. The MCA is a fundamental shift in the way that people who lack capacity, or are assumed to lack capacity, are supported to make decisions. As such, it will take time to embed it into a social care system

that historically has been characterized by relieving service users of decision-making.

This research project explores the impact of the MCA on a small number of disabled people with complex needs who live in communal residential settings that are part of Scope's adult services. See Appendix A for a more detailed summary of Mental Capacity Act provisions.

The Research Project

To carry out baseline measures in the area of independent living for disabled people, in order to affect a comparison with practice, following the implementation of the Mental Capacity Act.

The Project Plan

The project plan was to look at the decision-making process in six different situations to identify the role of different stakeholders in that process, and in particular that of the person who used the service. Stakeholders included managers of services, care staff, other professionals, families, advocates and the person using the service.

The study was carried out over a 12 month period. This allowed the researcher to identify a baseline of the involvement of service users in making decisions that affected their lives, and a comparison study six months after the Act had been implemented and staff had received initial training on the Act.

Specifically the research asked a number of questions:

- How were people who use services involved in choice and decision-making?
- What influence did others, such as different professionals and family members, have on choice and decision-making?
- What opportunity did people who use services have to direct and control their own life?
- How could the implementation of the Mental Capacity Act influence this?

Methodology and Data Collection

The study was carried out in two stages. The first stage was to establish a baseline of what people's lives in services were like before the full implementation of the MCA. The second stage was to undertake a comparative study to identify whether the Act had a practical impact on the decision-making process, by bringing about changes in the way staff carried out their duties.

Six people from three different Scope residential services across England were identified as suitable case studies. Participants were selected to include a range of abilities, a mix of gender and age. Four of those identified had family or an advocate who were involved in their care. These were included to see if they held any influence in the process. Although detail of specific ages was not requested, the youngest person was 23 and the oldest was in their late forties. There were two females and four males, all of whom were from white, British origins.

All three services were visited to address the issue of consent to take part in the project. Four service users were able to give consent and agreed to talk to the researcher. The other two were unable to give informed consent to take part. As the project was to identify the impact of the MCA for those who lack capacity, it was considered important to include people who may fit into this category in the study. A number of other professionals and family members were consulted on their views regarding the suitability of the remaining two to be participants in the research. All agreed that the research would not be intrusive and felt it was appropriate to involve them as there was a likely benefit to them directly, or to people with similar impairments. It was agreed that any research would cease immediately if there were concerns that it was causing any level of distress to those involved.

A number of quality of life outcomes were identified as a suitable guide to identify the level to which service users were involved in directing their own life. These were:

- Choice
- Decision-Making
- Being Valued
- Rights.

Workbooks were created in consultation with two service users (they were not involved in the research project) and their advocate. The workbook consisted of a set of statements to be scored depending on the level of agreement with them, and questions requiring written evidence designed to gather data on a number of key areas associated with quality of life outcomes. (Please see Appendix B for the full workbook for Stage One). For example:

- 'Service user chooses who they live with'
- or
- 'Service user is supported to make their own decisions'

Each statement was allocated a score between one and five, with additional boxes to be completed to provide written evidence to back up the statement. To get a realistic picture and address the risk of this exercise being too subjective, four workbooks were allocated to each of the six service users.

These were to be completed by different people involved in the service user's life:

- family member;
- service manager/other professional
- key worker/care staff
- and the service user who was supported to complete the book by their advocate or the researcher.

The process was explained to staff and family and the workbooks were given to the identified stakeholders who were asked to complete them based on their own perception of the quality of life outcomes for the services user.

The researcher spent two days in each of the three services, making direct observations and using unstructured interviews with the six service users chosen for the study. This formed the basis for the responses in four of the six service user workbooks, and offered an unbiased view when service users were unable to complete the workbook for themselves. The two other service users were supported to complete their own workbooks by their advocate. Interviews were also carried out with staff, managers, family members and an advocate to gain a better understanding about the life of the service users.¹

Unstructured interviewing involves direct interaction between the researcher and the respondent. The interviewer is free to move the conversation in any direction of interest that may come up. Consequently, unstructured interviewing is particularly useful for exploring a topic broadly.

¹ In direct observation the observer does not become a participant in the activity. However, the observer does strive to be as unobtrusive as possible so as not to bias the observations. Direct observation suggests a more detached perspective where the researcher is watching rather than taking part. The researcher is observing certain sampled situations or people rather than trying to become immersed in the entire context.

Results from Stage One

Scores from all workbooks were totalled to give a quantitative measure on the outcomes from all stakeholders. On their own, however, these figures gave little detail about real involvement in decision-making, without the more detailed backup written evidence. What the figures did show was a pattern in the way different groups scored. These were identified as follows:

- Members of staff returned significantly higher scores than others taking part in the study, for each of the outcomes.
- Managers and other professionals returned lower scores than care staff in the majority of areas.
- Staff and managers in one service returned very high scores in all areas. This was not mirrored by other professionals completing a workbook or by the service users and researcher. This could indicate the workbook process had not been fully understood or that the perception of those completing the books varied considerably.
- Family members returned roughly the same scores as other professionals but lower than members of staff.
- Service user scores were the lowest, particularly when the scores came from observations. In some instances service users themselves scored higher than the advocate and the researcher on their behalf, indicating that they felt they were involved more than was actually observed by others.

Findings by Outcomes

Choice and decision-making:

Choice was the area of least consistency in the scoring between the different groups and depended on individual interpretation. Decision-making was more consistent across the stakeholder groups.

- The lowest score was for service users choosing where to live. The majority of those involved in the study only scored one out of five in this area. There was no evidence that anyone had chosen to live where they were. Two people said they would like to live somewhere else.
- There was a significant difference in how staff interpreted choice compared to others involved in the study. In five out of the six cases staff considered that service users had a lot of choice. In reality, in all areas people were only involved in making the decision about choices they were offered (most of these being small everyday choices) for example 'do you want meat or fish for your dinner?' This is not the same as being in control of your own life. Staff perception was that giving people an 'either/or' choice of food or activity was true involvement and therefore they returned high scores. No choice was offered about what time of day to eat, whether to eat a hot meal or a cold snack or to be involved in the cooking and choosing of food. There was no evidence to show that anyone was involved in bigger decisions such as where they live and who they live with or whether they could take any risk in activities.
- One support worker recognized that choice was very restricted in all areas because it stopped at available options, and was dependent on a number of other factors i.e.
 - Availability of staff and transport for going out meant on some days there was no choice.
 - Limited options were available at meal times.
 - Who provided care support depended on staff rotas and therefore people could only choose who supported them from who was on duty. (i.e. male vs. female, individual's likes or dislikes of particular members of staff).
 - Selecting from a list of options for daytime activities (the list was limited to what staff saw as acceptable or appropriate).
- It was apparent that service users could only judge from personal experience of making choices. When this had always been limited, their expectations were significantly reduced. Quality of life then became subjective. Family members taking part in the study also had low expectations about real choice for those living in residential care.

- The researcher's view on the service users' opportunity to be involved in making choices was considerably different from those of the service users who were being supported to fill in workbooks. As a guide, the researcher compared choice against those who do not have a disability or those who do not use care services, and what their options might be. Service users had very low expectations guided only by previous history. Through this process, the researcher scored very much lower than others.
- There was some indication in the early stages of the research that those with greater communication skills had more involvement in making choices. The greater the individual's impairment or inability to give their consent, the less likely they were to have any control over their own life. It was not possible at this stage to identify how 'best interests' decisions had been made on behalf of service users.
- On further investigation into the process, people's scores reflected their ability to be involved, because of the severity of their disability. For example, one person had very low scores because others did not know for certain what they wanted. Early indications showed that staff made decisions on behalf of others without any formal process. Therefore those with more complex impairments tended to have less choice.

Some managers and other professionals recognised that in some circumstances it was not possible to understand what those with the most profound impairments liked or disliked, or even if some service users understood the choice process. This meant it was important that Stage Two of the research process focused on how 'best interests' decisions were made to identify if the MCA was being implemented and the level of involvement of those using the services.

Being Valued and Rights

There was little difference in the scoring for respect and being valued from any of the stakeholder groups. All scored highly. The majority of staff did show a level of respect for the service users in the way that personal care was provided and the way they were spoken to, but the standard of accommodation did not mirror this respect.

Service users who were able to comment thought that they were respected by others, but acknowledged that they did not have the same opportunities as their peers without a disability. This could be interpreted as meaning they were less valued than others.

All stakeholders found it difficult to score outcomes for one service user (A) because of the circumstances surrounding (A). (A) was currently using respite services because of concerns about (A)'s safety whilst at home. (A) was a long term user of the day service. Whilst the score when (A) was using services was high, (A)'s life was not judged to be the same at home and was considered to be less valued there.

Results from Stage Two

Throughout Stage One, it proved difficult to identify real choices being made because of the lack of understanding by staff of what constituted choice. Therefore Stage Two of the process focused on identifying how opportunities for making choices were presented rather than asking what choices are made.

Some changes were made to the workbooks for the second stage (see Appendix C for the full workbook for Stage Two) and the interview process, to take into account lessons learned from the first round of interviews and workbooks. The second workbook focused on identifying choice, decision-making, being valued and rights in each of the five following areas:

- Medication/health
- Personal care
- Community presence/activities
- Where to live/who to live with/moving on
- Money/finances

In workbook two, direct yes/no questions were asked as opposed to the scoring system that was used in workbook one. The intention at the beginning of the research was for the same staff to complete both workbooks, but due to significant staff changes in the services, this proved not to be possible.

The second workbook also asked direct questions on whether capacity tests had been carried out or 'best interests' decisions made on behalf of another person. Interviews took into account how 'best interests' decisions were made and how staff and managers assess 'capacity' for each person involved.

Findings

Of the six subjects of the study, two were deemed by staff to lack the capacity to make any choices or decisions in any of the areas identified. This view was also held by the researcher. However, staff were not aware that any formal assessment to ascertain capacity had been carried out or recorded in any of the areas of decision-making.

Subject (A)

It had been identified in the first stage of the research that this service user was the subject of a vulnerable adults investigation and it was indicated that an Independent Mental Capacity Advocate (IMCA) would be involved because of concerns about their family. (A) had been placed in full time respite care where (A) had previously lived at home and regularly attended the day centre. For the second stage of the research eight months later, (A) was still living in the respite service but returning to the family home at weekends.

No IMCA had been involved and there was no evidence that 'best interests' decisions had been made following the guidance of the MCA. The social work team was asked to respond to the research but failed to do so. No workbooks were returned to the researcher for the second stage of the project for this person. Through interviews with staff and managers at the day centre, it was evident that there was still considerable concern for this person. Although the manager had tried to ensure the MCA was implemented, the family had significant influence over any decisions that were made by others involved. All finances were managed by the family and staff were unable to access money that was needed to meet (A)'s basic daily needs.

The conclusion was reached from the evidence that was available that the Mental Capacity Act had no impact for this person.

Subject (B)

There had been an 'informal' process about recent medical treatment where the doctors had recommended a course of treatment to parents and family members but this had not been identified or recorded through a formal 'best interests' approach. The staff perception was that any medical treatment prescribed by a GP or hospital consultant had to be carried out by staff and they were not involved in the decision. The manager's view was that medical treatment had been prescribed through a multi-disciplinary process that included the family members.

Finances were managed by the family. All financial decisions for this service user were taken by the parents who responded to requests from staff when money was required.

Because of the complexity of (B)'s impairment, there was little evidence of them being involved in making decisions. There was no question about the level of care that was provided, but all decisions were made by family and on (B)'s behalf. It was

difficult to identify if these decisions would have been any different with greater involvement from the service user. What was lacking was the recognition that the service user had a right to be involved and that the MCA gave a process which should be followed when making best interests decisions. The conclusion was that the Act appears to have no impact for this service user.

Subjects (C) and (D)

For subjects (C) and (D), staff considered that they had full capacity to make decisions for themselves and that they were involved in all decisions that affect their life. Observations identified that they may have capacity to make some decisions, but they may have difficulty with others. No formal capacity test had been carried out for either of the subjects for any decisions. Recent decisions that had been made included dental surgery requiring general anaesthetic. This was recommended by the dentist and no capacity assessment was carried out.

For (C), their parents make all financial decisions and for (D) staff said that they managed their own finances and had their own bank account. During the interviews neither (C) nor (D) were able to identify how much money they had, where their money came from or if they had any savings. Both (C) and (D) said they asked either staff or family if they wanted any new personal items.

Observation and interviews identified that the life experiences of both (C) and (D) were very limited. They had lived in the same service for a significant number of years and although staff said they had never asked to move to another place, there was no evidence to show that alternatives were ever presented to them or that any care review process addressed future planning. Both had a limited lifestyle with minimal access to the wider community. They may well have chosen to maintain their current lifestyle but they were not furnished with enough information for them to have a clear understanding of what else was available to them. For this reason their choice was always limited. The restrictions placed on them were often related to the availability of staff to support them.

There was no evidence to show that the Mental Capacity Act had any impact for either (C) or (D). Frequent assumptions were made by staff because they felt they knew the service users well. Had capacity assessments been carried out, following the guidance laid out in the Act, there may well have been times when one or both were deemed to lack capacity for particular decisions. There was no doubt that they could have been involved through a 'best interests' approach to the level that their individual ability allowed.

Because the process identified in the Act was not followed, it may well restrict the lifestyles of both of these service users.

Subjects (E) and (F)

Service users (E) and (F) were both supported to complete the first workbook by their advocate. Through interviews, the researcher identified that there were a number of areas where the capacity of both may be called into account and therefore it would be appropriate for mental capacity assessments to be carried out.

- Both service users had indicated in the first interview that they would like to move and live somewhere else.
- No capacity assessment had been carried out and recorded to see if they understood the implications of this.
- Although appearing to have many skills, (E) had some difficulty in making decisions and choices because (E) always wanted to please others, leaving (E) open to significant influence by others, particularly family. Although (E) had made the decision to move to different accommodation this had not happened because the family were concerned about the risk that might be involved in considering a more independent life style for (E).
- Interviews with staff indicated that at times when decisions made by service users were considered to be 'unwise', the opportunity to do something was denied through a risk assessment process. For example, not being able to use their electric wheelchairs outdoors; having to follow diets prescribed by others because of concerns by staff about healthy eating; being fed through a gastro tube because of the risk of choking, even though the service user might wish to continue to eat regular meals.
- Service users were not offered the same opportunities as their non-disabled peers. For example, they had to seek permission to go out or they were not able to manage their own finances because of the organisational's finance policies. No-one was able to keep their money in their room and had to ask staff if they wanted anything.

Service user (F) did not wish to take part in the second interview process and therefore evidence was patchy. The advocate said that nothing had changed from the first interview six months previously, with regard to (F) being able to move to new accommodation. Although it had been discussed, there were no plans for a move in place. There was some evidence to show that the Mental Capacity Act was not having an impact on the lives of (E) and (F).

Interpretation of findings from observations and interviews

There were obvious difficulties in the ability of staff to promote real choice in care settings that still exhibit as being institutional. Their ability to involve people in real decisions, equal to those outside of these systems was seen to be 'unrealistic'. Staff followed old habits and routines. There is a greater challenge to be met if the Mental Capacity Act is to bring about change in the way that care services for disabled people are provided.

It will take time to change people's ways of working and to initiate a cultural change in service provision. In reality, service users have very few real choices because of the way that current services are purchased and provided. Choosing where to live or who to live with is at present not a reality and it is difficult to see how the MCA will influence this as there are many other opposing factors. Limited finance and budgets and the way local authorities purchase services is currently the biggest barrier.

When life experience has been significantly limited because of disability and a life lived in services, people's expectations are significantly reduced. The ability to choose a life comparable to the majority population is limited because of the lack of knowledge and understanding of individual rights and what may be available options.

At the early stage of the study, it was evident that there is a clear tension between duty of care and the ability of individuals to make choices and decisions. Many decisions appear to rest on risk assessments and what is required from Minimum Care Standards and the Inspection of Care Homes process. There is a tendency to be risk averse rather than to look at how risk can be minimised and managed to allow service users to make their own choices.

The way that people were supported to manage and control their own life varied across services. There was little consistency and it depended on the personal values of the individual staff and managers involved. Some services also had access to a greater number of other professionals, such as speech and language therapists, physiotherapist and psychologists, which improved the quality of the support that was offered.

The majority of staff considered that many service users' wishes were ignored because of the influence of family members whose views took priority.

Of the 14 members of staff who took part in the study, only one had received no training on the Mental Capacity Act. All the others had attended training sessions about the Act, although knowledge varied depending on who had delivered the training. During the interviews with staff there were signs that some were still unclear about their duties under the Act.

Barriers to implementing the Act

Members of staff interviewed thought that living in large residential homes that were institutional would always place restrictions on personal choice for the residents, regardless of the MCA.

Lack of adequate resources was seen as a barrier to staff in implementing the Act. Whilst service users could be supported to make significant choices and decisions, this did not always happen because staff felt that unrealistic and unachievable choices may be made and it was often considered unfair to offer options that may not be available. Examples given were:

- There were not always enough staff on duty to support service users to undertake the activities they were interested in.
- Personal finances and sufficient support of staff restricted service users from making certain choices about holidays.
- Choices about different accommodation and where to live was restricted by what local authorities were prepared to pay for and by the fact that some local authorities insisted on service users living in their county of origin.

The level of service users' communication skills was a significant factor in the research. In a number of areas it was thought that although service users appeared to have the ability to be involved in decisions, in reality their ability to understand the consequences of actions was very limited and therefore they should not really be considered to have the capacity to make these decisions. In other situations, when a service user had good communication skills, it was an automatic assumption that they had the capacity to make their own decisions.

The influence of other professionals was another factor that inhibited staff in supporting service users to be involved in decision-making. Care staff frequently felt that they were undermined by others who they saw as being in higher authority, such as medical professionals, therapists or care managers.

Staff were often concerned about their personal liability if something were to go wrong. This had a significant impact on their willingness to support service users to make 'unwise' decisions where there was a possibility that it could result in injury or poor health.

Analysis

Despite best efforts to involve a range of stakeholders in the research, it was difficult to get professionals outside of the direct service to engage with the process. What is therefore missing in the research is the direct perspective of care managers and social work teams, and some groups of medical professionals such as GPs, and medical consultants such as psychiatrists.

Those who were truly unable to consent to the research process, and are therefore more likely to be having decisions made for them by others, were not able to be interviewed. Although the impact made by the Act (or otherwise) could be identified through the observation process, there would have been added benefit to the research if an independent advocate that knew the service user well had been involved. Only in one of the services was advocacy available and in general terms the lack of available advocacy may reduce the impact of the Mental Capacity Act, because there is no one involved to ensure that the voice of the service user is genuinely heard and taken into account.

The sample for this research project was small and it is therefore not possible to make any generalisations for the research outcomes. However, given the widespread institutionalisation of residential services for disabled people with complex disabilities, together with the culture of risk aversion, we could speculate that similar findings are likely to be found in similar settings.

Conclusion

At this early stage in the implementation of the MCA, there was no evidence to show that the Act was having an impact on the lives of the service users in the study. Yet there were examples where the Act could have had considerable influence had it been implemented.

There was evidence to show that the greater the communication skills of the individual service users, the more likely they were to be considered to have the capacity to make decisions. If people had some formal methods of communication then there tended to be a view held by staff that the service user had the capacity to make all the decisions in their life, without the need to carry out capacity assessments. Those that had limited traditional communication skills were less likely to be considered to have the capacity to make any decisions and therefore capacity assessments were not carried out. Decisions were made by others without a 'best interests' approach or process being followed.

Training on the Mental Capacity Act had been received by the majority of staff, although not by the families of service users. Training did not change their approach to their work and there was evidence that a greater cultural change is required in services if they are to become more inclusive of the views of the people who use them. Blanket decisions were still being made about the capacity of service users to be involved in decision-making because of the level of their disability.

Choice and decision-making was limited to what suggestions and options were put forward by members of staff. Service users were rarely empowered enough or had the relevant information available to them, to understand there were wider choices to be had. They had very little control of their own life and had very low expectations of what they could achieve. This was compounded by the fear staff had of causing distress or upset if what they considered to be 'unrealistic' choices were offered. There appeared to be an assumption by staff that once people were living in the care service system, there was no need to look at lifestyle alternatives.

What is clear is that the principles that underpin the MCA clash with the culture of 'care' that is both embedded in services provision via legislation on 'care standards' and institutionalised by the well meaning but essentially paternalistic attitudes towards disabled people. As such we should not be too surprised by the results of this research. This makes it more urgent that the lesson learned should be translated into actions.

Recommendations:

Service Providers

The research project identified a need for more staff training and guidance from the organisation on the issue of mental capacity and its assessment. There was considerable variety in the way that staff perceived judgements should be made and who should make them. The Mental Capacity Act outlines that what is in a person's best interests is decided only *after* assessing their capacity. Frequently decisions were being made that were considered to be in a person's best interests without any capacity assessment being made. This is an example of the confusion that exists.

It can be argued that a central reason for introducing the Act was to address the diversity of opinion of what is meant by capacity, and how and by whom should this be assessed. The Act does introduce a standard, simple, two-stage test of capacity and the Code of Practice provides guidance on how to ensure individually tailored and appropriate tests for the person and situation. Producing standardised organisational guidelines on the understanding of capacity, assessment of capacity (how and when to assess), and best practice regarding who and when to involve others in assessment and 'best interests' decisions, would ensure that staff had a greater understanding of their responsibilities.

Supporting Service Users

Whilst pockets of good practice do exist, more attention must be paid to supporting service users to express their needs appropriately and to give them the confidence to make their own decisions. This requires a significant change in culture and the way that services have traditionally been delivered. Staff need to have the confidence to know that it is appropriate for them to challenge the views of other professionals when a person's ability to make decisions is in question, or when 'best interests' decisions are being made on another person's behalf.

Family and Carers

Family carers often have much to offer staff and services in their knowledge and experience of their family member, and vice versa. Mutual ways of working would benefit everyone and much could be gained for the individual service user if partnerships working between staff and family could be achieved. Training sessions for family members about the Mental Capacity Act would give them a greater insight into what is expected from staff and their duties under the Act. Services need to support the family members' own needs in a completely accessible way. In addition, training sessions delivered by family members to staff would help staff to understand the perspective of parents who may have very real concerns about their adult children.

Commission for Social Care Inspectorate

The dilemma for staff between 'duty of care' and implementing the Mental Capacity Act is very real. Staff found it hard to see where their responsibility lay and some clear guidance from the Commission for Social Care Inspection on the management of risk and supporting service users when they make what may be considered to be 'unwise' decisions or decisions that might expose them to risk is urgently needed. Staff need to be assured that they are correct to support decisions, even when they do not necessarily agree with them.

Specific issues for service providers:

- There needs to be a recognition of the institutional restraints that exist around the decision-making process for individuals.
- There needs to be some guidance on where responsibility for implementing the Act lies. What is corporate and what is the responsibility of individual staff?
- There needs to be more resources in place to support service users to make their own decisions (staff time, confidence building, and time taken around decisions). This links to the idea of direct payments and development of personal budgets which will enable disabled people living in a community setting more control over their lives.
- Services must be able to demonstrate how they have made capacity decisions and how they have involved service users and their carers (including family members and frontline care staff), in the determination of the person's best interests.
- Services need to ensure there is the provision of support and mentoring for their staff to enable them to apply the Act in their everyday practice. This will require additional resources.
- There needs to be a consistent strategy across services to communicate guidance and training on the Act for frontline staff. Joint training with family carers would benefit all parties and promote partnership working.
- Additional training on issues such as good communication, supporting choice and user involvement and managing risk would benefit all levels of staff.
- Finally and crucially there has to be access to advocacy for service users

Appendix A – Summary of Mental Capacity Act*

**Taken from the summary by the Department for Constitutional Affairs at www.dca.gov.uk/legal-policy/mental-capacity/mca-summary.pdf*

Mental Capacity Act 2005 – summary

The Mental Capacity Act 2005 for England and Wales received Royal Assent on 7 April 2005 and will come into force in 2007. The Act will generally only affect people aged 16 or over and provides a statutory framework to empower and protect people who may lack capacity to make some decisions for themselves, for example, people with dementia, learning disabilities, mental health problems, stroke or head injuries who may lack capacity to make certain decisions. It makes it clear who can take decisions in which situations and how they should go about this. It enables people to plan ahead for a time when they may lack capacity. The Act will cover major decisions about someone's property and affairs, healthcare treatment and where the person lives, as well as everyday decisions about personal care (such as what someone eats), where the person lacks capacity to make the decisions themselves.

This summary provides key information about the new Act and sets out some of the changes that will occur as from April 2007.

Parts of the Act will be available from April 2007, however most of the Act will come into force in October 2007. This summary provides information on the Act and when the different parts will be available.

Five key principles:

The whole Act is underpinned by a set of five key principles set out in Section 1 of the Act:

- A presumption of capacity – every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise;
- Individuals being supported to make their own decisions – a person must be given all practicable help before anyone treats them as not being able to make their own decisions;
- Unwise decisions – just because an individual makes what might be seen as an unwise decision, they should not be treated as lacking capacity to make that decision;
- Best interests – an act done or decision made under the Act for or on behalf of a person who lacks capacity must be done in their best interests; and
- Less restrictive option – anything done for or on behalf of a person who lacks capacity should be less restrictive of their basic rights and freedoms.

What does the Act do?

The Act enshrines in statute current best practice and common law principles concerning people who lack mental capacity and those who take decisions on their behalf. It replaces current statutory schemes for Enduring Powers of Attorney and Court of Protection receivers with reformed and updated schemes.

The Act deals with the assessment of a person's capacity and acts by carers of those who lack capacity (these will all come into effect in October 2007):

- **Assessing lack of capacity** – The Act sets out a single clear test for assessing whether a person lacks capacity to take a particular decision at a particular time. It is a “decision-specific” and time specific test. No one can be labelled ‘incapable’ simply as a result of a particular medical condition or diagnosis. Section 2 of the Act makes it clear that a lack of capacity cannot be established merely by reference to a person’s age, appearance, or any condition or aspect of a person’s behaviour which might lead others to make unjustified assumptions about capacity.
- **Best Interests** – An act done or decision made for or on behalf of a person who lacks capacity must be in that person’s best interests. The Act provides a non-exhaustive checklist of factors that decision-makers must work through in deciding what is in a person’s best interests. A person can put his/her wishes and feelings into a written statement if they so wish, which the person making the determination must consider. Also, people involved in caring for the person lacking capacity gain a right to be consulted concerning a person’s best interests.
- **Acts in connection with care or treatment** – Section 5 offers statutory protection from liability where a person is performing an act in connection with the care or treatment of someone who lacks capacity. This could cover actions that might otherwise attract criminal prosecution or civil liability if someone has to interfere with the person’s body or property in the course of providing care or treatment.
- **Restraint** – Section 6 of the Act sets out limitations on section 5. It defines restraint as the use or threat of force where a person who lacks capacity resists, and any restriction of liberty or movement whether or not the person resists. Restraint is only permitted if the person using it reasonably believes it is necessary to prevent harm to the person who lacks capacity, and if the restraint used is a proportionate response to the likelihood and seriousness of the harm. This section does not extend to deprivation of liberty within the meaning of Article 5(1) of the European Convention on Human Rights. However the Government has proposed to amend the Mental Capacity Act by introducing additional safeguards for people who lack capacity and are deprived of their liberty to protect them from harm, who are in hospitals and care homes, but who do not receive mental health legislation safeguards. This is as a result of the European Court of Human Rights judgement in *HL v United Kingdom* (the “Bournemouth” case). The Deprivation of Liberty Safeguards will be implemented in April 2009 and are being introduced via the Mental Health Act 2007, although the safeguards will amend the Mental Capacity Act, if approved by Parliament.

The Act deals with two situations where a designated decision-maker can act on behalf of someone who lacks capacity:

- **Lasting Powers of Attorney (LPAs)** – The Act allows a person to appoint an attorney to act on their behalf if they should lose capacity in the future. This is like the current Enduring Power of Attorney (EPA) in relation to property and affairs, but the Act also allows people to empower an attorney make health and welfare decisions. Before it can be used an LPA must be registered with the Office of the Public Guardian (see below). EPAs created before October 2007 can be registered after the implementation date but it will not be possible to create EPAs after this time. LPA's will be available from October 2007.
- **Court appointed deputies** – The Act provides for a system of court appointed deputies to replace the current system of receivership in the existing Court of Protection. Deputies will be able to be appointed to take decisions on welfare, healthcare and financial matters as authorised by the new Court of Protection (see below) but will not be able to refuse consent to life-sustaining treatment. They will only be appointed if the Court cannot make a one-off decision to resolve the issues. People appointed as receivers before October 2007 will retain their powers concerning property and affairs after the implementation date in October 2007 and will be treated as deputies after this time.

The Act creates a new public body and a new official to support the statutory framework, both of which will be designed around the needs of those who lack capacity:

A new Court of Protection – The new Court will have jurisdiction relating to the whole Act. It will have its own procedures and nominated judges. It will be able to make declarations, decisions and orders affecting people who lack capacity and make decisions for or appoint deputies to make decisions on behalf of people lacking capacity. It will deal with decisions concerning both property and affairs, as well as health and welfare decisions. It will be particularly important in resolving complex or disputed cases involving, for example, about whether someone lacks capacity or what is in their best interests. The Court will be based in venues in a small number of locations across England and Wales and will be supported by a central administration in London. The Senior Judge designate of the Court is the current Master Lush. The new Court will be launched in October 2007.

- **A new Public Guardian** – The Public Guardian has several duties under the Act and will be supported in carrying these out by an Office of the Public Guardian (OPG). The Public Guardian and his staff will be the registering authority for LPAs and deputies. They will supervise deputies appointed by the Court and provide information to help the Court make decisions. They will also work together with other agencies, such as the police and social services, to respond to any concerns raised about the way in which an attorney or deputy is operating. A Public Guardian Board will be appointed to scrutinise and review the way in which the Public Guardian discharges his functions. The Public Guardian will be required to produce an Annual Report about the discharge of his functions. Martin John has been appointed the new Public Guardian and Chief Executive of the Office of the Public Guardian (OPG). Richard Brook is the new Public Guardian designate. He is

currently the Chief Executive of the Public Guardianship Office. The Public Guardianship Office (PGO), based in Archway, North London, will become the Office of the Public Guardian (OPG) in October 2007.

The Act also includes three further key provisions to protect vulnerable people:

- **Independent Mental Capacity Advocate (IMCA)** – An IMCA will be someone appointed to support a person who lacks capacity but has no one to speak for them, such as family or friends. They will only be involved where decisions are being made about serious medical treatment or a change in the person's accommodation where it is provided by the National Health Service or a local authority. The IMCA makes representations about the person's wishes, feelings, beliefs and values, at the same time as bringing to the attention of the decision-maker all factors that are relevant to the decision. The IMCA can challenge the decision-maker on behalf of the person lacking capacity if necessary. The IMCA service will be available from April 2007 in England together with related elements of the Act to support it e.g. assessing capacity and best interests. In Wales the IMCA service will be available from October 2007.
- **Advance decisions to refuse treatment** – The Act creates statutory rules with clear safeguards so that people may make a decision in advance to refuse treatment if they should lack capacity in the future. The Act sets out two important safeguards of validity and applicability in relation to advance decisions. Where an advance decision concerns treatment that is necessary to sustain life, strict formalities must be complied with in order for the advance decision to be applicable. These formalities are that the decision must be in writing, signed and witnessed. In addition, there must be an express statement that the decision stands "even if life is at risk" which must also be in writing, signed and witnessed. You will be able to make advance decisions from October 2007.
- **A criminal offence** – The Act introduces a new criminal offence of ill treatment or neglect of a person who lacks capacity. A person found guilty of such an offence may be liable to imprisonment for a term of up to five years. The new criminal offence will be effective from April 2007.

The Act also sets out clear parameters for research, which will start in October 2007:

- Research involving, or in relation to, a person lacking capacity may be lawfully carried out if an "appropriate body" (normally a Research Ethics Committee) agrees that the research is safe, relates to the person's condition and cannot be done as effectively using people who have mental capacity. The research must produce a benefit to the person that outweighs any risk or burden. Alternatively, if it is to derive new scientific knowledge it must be of minimal risk to the person and be carried out with minimal intrusion or interference with their rights.
- Carers or nominated third parties must be consulted and agree that the person would want to join an approved research project. If the person shows any signs of resistance or indicates in any way that he or she does not wish to take part, the person must be withdrawn from the project immediately.

Code of Practice

- There will be a statutory Code of Practice to accompany the Act. The Code will provide guidance to all those working with and/or caring for adults who lack capacity, including family members, professionals and carers. It describes their responsibilities when acting or making decisions with, or on behalf of, individuals who lack the capacity to do these things themselves. Those who will have a duty of care to a person lacking capacity, such as attorneys, deputies, IMCAs, professionals and paid carers must have regard to the Code. The Code of Practice will be available from April 2007.

Excluded Decisions

- Some types of decisions can never be made by another person on behalf of another person who lacks capacity and the Act does not change this. This is because these decisions or actions are either so personal to the individual or because other laws govern them. These include decisions such as marriage or civil partnership, divorce, sexual relationships and voting. They also include decisions about treatment for mental disorder where someone is being detained and treated under Part 4 (Consent to Treatment) of the Mental Health Act which allows the person to be treated without their consent.

Appendix B:

A workbook for checking
the impact of the
Mental Capacity Act
for people who use Scope services

for staff members

(A) Name of person supported by Scope services

(B) Name of person completing workbook

(C) Relationship or job role to person named in (A)

(D) Contact details of person completing form

Outcome One – Making everyday choices

Look at the statements below and score them between 1 and 5. 1 indicates very little choice and 5 when there is a lot of opportunity for choice.

You need to answer the questions as **you** see things for that person. You do not need to ask the person.

- Service user chooses who they live with
- Service user chooses where they live
- Service user chooses who supports them
- Service user chooses what support they need
- Service user chooses what happens in the home
- Service user chooses what they have to eat and drink
- Service user chooses what they do in the daytime

Outcome One – Making everyday choices

List what choices you have seen or know about, and how these choices are made (the 'evidence'). If you think that the service user is limited in their opportunity to make choices give your reasons.

Outcome Two – Greater participation in making decisions

Look at the statements below and score them between 1 and 5. 1 indicates very little involvement in making decisions and 5 when a person always makes their own decisions.

You need to answer the questions as **you** see things for that person. You do not need to ask the person.

- Service user is supported to make their own decisions (The person has an up to date Person centred plan/action plan/care plan, and were involved in drawing it up)
- Service user takes part in activities they are interested in, have been involved in planning, and seen as important to others. (People are taking time to understand how the person communicates choices and can show why activities are chosen and that they are meaningful to the individual concerned)
- Service user makes friendships and relationships on their own terms (People are thinking of creative ways of understanding what is important to the person in developing personal relationships)

Outcome Two – Greater participation in making decisions

Record here what you have seen or know about that makes you think this person is involved in making decisions that affect their life, and how they are involved (the evidence). If you think that the service user is not given the opportunity to make decisions, give your reasons.

Outcome Three – Being Valued

Look at the statements below and score them between 1 and 5. 1 indicates they are not really valued and 5 when they are highly regarded and respected. You need to answer the questions as **you** see things for that person. You do not need to ask the person.

- Service user is treated with respect.
(Personal care is carried out in a dignified way that includes talking to the person about what is happening and why)
- The service user is supported to be healthy and safe. (They get the same health checks and access to specialist services as someone who does not use services. They visit the GP regularly)
- Service user is part of the local community and has the opportunity to do similar things to others of the same age that do not use services.
- Service user is safe from bullying and abuse
(Staff involved understand about adult protection and what to do if they think the person is being hurt or abused)
- Others who are important to the service user are involved in making the decisions that affect their life (The person has an advocate/ family who are always involved in review meetings and care planning meetings. The advocate/family are contacted when important decisions are made or in emergencies)

Outcome Three – Being Valued

Record here what you have seen or know about that makes you think this person is valued for who they are (the evidence). If you think the person is not valued, give your reasons.

Outcome Four – Rights being upheld

Look at the statements below and score them between 1 and 5. 1 indicates their rights are very restricted and 5 that their rights are respected at all times. Answer the questions as **you** see things for that person. You do not need to ask the person.

- Service user has the same rights and responsibilities as other people who are not disabled or supported by services (Those who work with the person understand about Human Rights, equal opportunities and diversity)
- Service user has the right to say what happens to them (Can the following statement be evidenced? "My life belongs to me and I should be included in deciding how I live it")
- Service user has the right to take risks (Do risk assessments and duty of care stop the person from doing things that are different and exciting?)
- Service user has a right to be communicated with in ways they can understand. (Person has an up to date assessment by a speech and language therapist with a communication passport that identifies how they like to be communicated with. Appropriate communication aids are used that are suited to the individual)

Outcome Four – Rights being upheld

Record here what you have seen or know about that makes you think this person's rights are being upheld (the evidence). If you think the person's rights are not respected, please give the reason why you believe this.

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Have you received training about the Mental Capacity Act? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do people using the Scope service have access to an advocate? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you think that service user's involvement in controlling their own life is restricted because of other influences i.e. | | |
| a) other professionals | <input type="checkbox"/> | <input type="checkbox"/> |
| b) family carers | <input type="checkbox"/> | <input type="checkbox"/> |
| c) lack of sufficient resources | <input type="checkbox"/> | <input type="checkbox"/> |
| d) other (please state) | <input type="checkbox"/> | <input type="checkbox"/> |

- | | | |
|---|--------------------------|--------------------------|
| 4. Do you think the Mental Capacity Act will help you in your work | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Does your organisation have a "whistle blowing" policy that you would feel confident you could use if you felt others were not adhering to the Mental Capacity Act | <input type="checkbox"/> | <input type="checkbox"/> |

Thank you for completing this workbook

Human Rights Act 1998

I should:

- **Be able to say what I like as long as I respect other people**
- **Make choices about my life**
- **Expect people to listen to me**
- **Get information about my rights**
- **Have my rights respected**
- **Be safe at home and have time to myself**
- **Get information about my health and treatment**

I can:

- **Speak out and complain if something is wrong**
- **Choose the people I want to see and who my friends are**
- **Get married and have children**
- **Live with people I get on with**
- **Decide what I spend my money on and get paid for the work I do**

It is wrong for anyone to:

- **Shout at me, call me names, hit or hurt me**
- **Force me to have sex or abuse me**
- **Take my things or money away**
- **Lock me in or stop me going out**
- **Punish me**

It is wrong for anyone to treat me badly because of:

- **Being a man**
- **Being a woman**
- **My skin colour**

- **My health or disability**
- **My religion**
- **How I communicate**

Appendix C:

A workbook for checking
the impact of the
Mental Capacity Act
for people who use Scope services

for staff members
Workbook phase two

(A) Name of person supported by Scope services

(B) Name of person completing workbook

(C) Relationship or job role to person named in (A)

(D) Contact details of person completing form

Section One

Medication/health

Answer yes or no by inserting a tick in the boxes for the following questions. You need to answer the questions as **you** see things for that person. You do not need to ask the person.

If any of the questions are not relevant to the person please put n/a (not applicable) in the answer space

		Yes	No
1.	Service user takes regular medication (if no move on to question 5)		
2.	Service user understands why they take medication		
3.	Does the service user choose to take medication		
4.	Do staff/manager/other decide if the person should take medication		
5.	Service user has flu vaccine/other immunisation		
6.	Service user is involved in choosing if they want the immunisation		
7.	Service user has regular medical check ups/screening		
8.	Service user has visited hospital/GP in the past six months		
9.	Service user is involved in making the decision to visit the hospital/GP		
10.	Service user has undergone medical treatment in the past six months		
11.	Service user was involved in making the decision about the medical treatment		

Medication/health (Please enter don't know if you have no knowledge about any of the following)

1.1 How is the service user involved in making choices about taking medication and helped to understand why they take medication?

1.2 How is the service user included in making decisions to visit the doctor/hospital?

1.3 Have any medical decisions been taken in the past six months (medication, hospital/GP treatment)	Yes
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No

1.4 Was a capacity test carried out to see whether the person had the capacity to be involved in the decision. (If yes go to question 1.5. and continue. If no move on to 1.11)	Yes
--	------------

No

1.5 Who carried out the capacity test? (Please give job title or role, not personal name)	
1.6 How and where was the test recorded in records?	
1.7 Did the person pass the capacity test	Yes No
1.8 Was a 'Best Interest' decision made on behalf of the person? (if no move on to question 1.11)	Yes No
1.9 Who was consulted and involved in the 'Best Interest' decision (status of people for example family, social worker, care staff etc)	
1.10 Where and how was the process recorded?	
1.11 Were decisions made on behalf of the service user because those involved thought that the person lacked the capacity to understand the situation? (If yes, please give details)	Yes No

Section Two

Personal Care

Answer yes or no by inserting a tick in the boxes for the following questions. You need to answer the questions as **you** see things for that person. You do not need to ask the person.

If any of the questions are not relevant to the person please put n/a (not applicable) in the answer space.

		Yes	No
1.	Is service user involved in deciding how they want personal care needs met?		
2.	Does the service user have a personal care plan?		
3.	Was the service user involved in drawing up the care plan?		
3.	Does the service user have some choice in who delivers their personal care?		
4.	Can a service user choose how often they have a bath		
5.	Does the service user have all the necessary mobility aids to encourage independence wherever possible		

Personal Care (Please enter don't know if you have no knowledge about any of the following).

2.1 How is the service user involved in making choices about how their personal care needs are met and who delivers the personal care? for example communication aids, behaviour, signing,

2.2 What steps are taken to ensure that a person's dignity is respected?

2.3 What steps are taken to ensure that the service user is encouraged to be independent?

Section three

Community presence/activities

Answer yes or no by inserting a tick in the boxes for the following questions. You need to answer the questions as **you** see things for that person. You do not need to ask the person.

If any of the questions are not relevant to the person please put n/a (not applicable) in the answer space.

		Yes	No
1.	Does the service user take part in regular activities outside of the home? (Please state how often is regular?)		
2.	Does the service user choose what activities they take part		
3.	Does the service user have regular contact with people other than members of staff? (If yes, please state who)		
4.	Does the service user have regular care reviews? (Please state how often)		
5.	Does the service user take part in shopping trips for personal items and groceries?		
6.	Is the Service user involved in the running of the home for example cooking, care of own rooms, laundry etc		
7.	Does the service user use public amenities for example restaurants, pubs, sport and leisure facilities, public transport etc? (If yes, please state which)		
8.	Does the service user access local medical services for example the local GP, dentist, hospital (If yes, please state which)		

Community presence/activities (Please enter don't know if you have no knowledge about any of the following)

3.1 How is the service user involved in making choices about what activities they want to take part in?

3.2 How is the service user supported to keep contact with others outside of the care establishment in which they live? for example family, friends

3.3 How is the service user encouraged and supported to take part in everyday activities for example work, leisure, social, domestic

3.4 What measures are taken to make sure that the service user is safe from harm or abuse?

3.5 How do others know when the service user is happy or sad?

Section four

Where to live, who to live with

Answer yes or no by inserting a tick in the boxes for the following questions. You need to answer the questions as **you** see things for that person. You do not need to ask the person.

If any of the questions are not relevant to the person please put n/a (not applicable) in the answer space.

		Yes	No
1.	Was the service user involved in choosing where they live?		
2.	Was the service user's family involved in choosing where they live?		
3.	Does the service user have some choice in who they live with?		
4.	Can a service user choose what furniture they have in their room?		
5.	Does the service user have their own possessions for example television set, radio, music, pictures etc (if yes, please indicate what)		
6.	Does the service user have regular reviews that address whether the home still meets their needs? If yes, how often.		
7.	Is the service user given the opportunity to 'move on' or find new accommodation		
8.	In the last six months, has consideration been given to finding a new home for the service user?		

Where to live/who to live with (Please enter don't know if you have no knowledge about any of the following).

4.1 How is the service user involved in making choices about where they live and who they live with?

4.2 How is the service user included in making decisions about what happens within the home?

4.3 What opportunity is the service user give to make changes to their living arrangements and move on if they want to

4.4 Have any discussions taken place in the last six months about changes in living accommodation?	Yes No
4.5 Has a capacity test been carried out to see whether the service user has the capacity to be involved in any discussions and decisions around where they would like to live. (If yes go to question 1.6. and continue. If no move on to 1.11)	Yes No
4.6 Who carried out the capacity test? (Please give job title or role, not personal names)	
4.7 How and where was the capacity test recorded in records?	
4.8 Did the person pass the capacity test	Yes No
4.9 Was a 'Best Interest' decision made on behalf of the person? (if no, please move on to question 4.14	Yes No
4.10 Who was consulted and involved in the 'Best Interest' decision (Please give status of people for example family, social worker, care staff etc, nor personal names)	
4.11 Where and how was the process recorded?	
4.12 Were decisions made on behalf of the service user because those involved thought that the person lacked the capacity to understand the situation? (If yes, please give details)	Yes No

Section five

Money/finances

Answer yes or no by inserting a tick in the boxes for the following questions. You need to answer the questions as **you** see things for that person. You do not need to ask the person.

If any of the questions are not relevant to the person please put n/a (not applicable) in the answer space.

		Yes	No
1.	Does the service user take any part in deciding how their money is used		
2.	Does the service user understand where their money comes from (for example benefits and what they are for/other income)		
3.	Does the service user have savings		
4.	Do they know about any savings?		
5.	Does the service user have access to their money?		
6.	Does the service user keep their money in their own room?		
7.	Does the service user have their own bank account		

Money/finances (Please enter don't know if you have no knowledge about any of the following).

5.1 How is the service user involved in making decisions about how their money is used?

5.2 How is the service user included in deciding whether they want to save money or spend it?

5.3 What opportunity is the service user given to make choices about how their money is used?

5.4 Has a capacity test been carried out to see whether the service user has the capacity to be involved in any discussions and decisions around their finances? (If yes go to question 5.5 and continue. If no move on to 5.11)

Yes
No

5.6 Who carried out the capacity test? (Please state role or hob title of person not personal name)

5.7 How and where was the capacity test recorded in records?	
5.8 Did the person pass the capacity test	Yes
	No
Was a 'Best Interest' decision made on behalf of the person about purchasing any items or making savings? (if no, please move on to question 5.11)	Yes
	No
5.9 Who was consulted and involved in the 'Best Interest' decision (Please give detail of status of people for example family, social worker, care staff etc not personal name)	
5.10 Where and how was the process recorded?	
5.11 Were decisions made on behalf of the service user because those involved thought that the person lacked the capacity to understand the situation? (If yes, please give details)	Yes
	No

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