

The Mental Capacity Act 2005: what it does and some thoughts on its impact on practice

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Abstract

This article outlines the main principles of the Mental Capacity Act 2005 (MCA). The introduction briefly explains the background to the development of the legislation and introduces some of the principles underpinning the Act before going on to look at the Best Interest check list, the protection from liability offered practitioners by the act and the safeguards offered to service users by the legislation.

Introduction.

This legislation is based on rules established by case law about how to work with people who lack capacity (either on a temporary or permanent basis). The Act provides a definition of capacity, a functional test for capacity (see Box 1) and a checklist for Best Interest decision making which are underpinned by five key principles (See box 2). The Act is supported by a Code of Practice. The Act, which applies to all adults aged 16 years or over (with some exceptions), provides a clear definition of incapacity, and for deciding if a person lacks capacity in respect of a particular matter.

Box 1. Testing Capacity

The responsibility for testing capacity rests with the person who wishes to make a decision on behalf of someone who lacks capacity.

The functional test of capacity:

1. Does the person have an impairment or disturbance in the functioning of his mind or brain?
2. Does the impairment or disturbance make the person unable to
 - Understand the information relevant to that decision;
 - Retain that information long enough to reach a decision;
 - Use or weigh that information as part of the process of making the decision; or
 - Communicate his decision (whether by talking, using sign language, visual aids or any other means).

“A person lacks capacity in relation to a decision or proposed intervention if, at the material time, he is unable to make a decision for himself in relation to the matter or proposed intervention because of an impairment of, or a disturbance in the functioning of

the mind or brain. It does not matter whether the impairment or disturbance is permanent or temporary.” (S2 (1) and (2) MCA 2005.

Box 2. Principles (based on section 1 MCA 2005)

1. Best interests always.
2. Less restrictive care provision option.
3. Encourage individual to make own decisions.
4. Eccentric decisions are OK.

It is important to note that the decision is always ‘time specific’ and ‘issue specific’. It is also a test applied both to people with temporary or fluctuating capacity (such as people experiencing mental ill-health) and those whose decision making ability is permanently impaired (such as people with a learning disability). The Act starts from the presumption that those we work with *do* have capacity, and requires staff to involve them as much as possible in their own treatment and care including when there is evidence that they lack capacity in a particular matter. The Act also introduces a statutory right to advocacy for those lacking capacity and “unbefriended” through the Independent Mental Capacity Advocacy Service (IMCA), Lasting Powers of Attorney for health and welfare and property and finance and two new criminal offences, i.e. “the wilful neglect or ill treatment of a person lacking capacity” (S 44 MCA 2005.)

The MCA will also apply when someone is detained under the Mental Health Act 1983. For example if the person lacks capacity to consent to treatment for

a physical health issue rather than treatment related to *mental disorder*. The Act has introduced safeguards for medical practitioners when working with advanced decisions made by people in advance for how they wish to be treated when or if they lose capacity in the future.

Best Interests Check List.

The best interests checklist represents the issues that decision makers must consider when decisions or interventions are made on behalf of someone who lacks capacity, if the decisions (and the decision maker) are to be protected by the MCA

The checklist items include that the decision maker:-

- Must not make their judgement based merely on the person's age, appearance, condition (or diagnosis);
- Must take into account whether the person is likely to regain capacity with regard to the decision in hand, and whether the decision can wait;
- Must as far as reasonably practicable, 'permit and encourage' the person to communicate, including by acting to improve his or her ability to communicate (for example, by using an advocate);
- Must not, where the decision relates to life sustaining treatment, be motivated by a desire to bring about the relevant person's death;
- Must so far as is possible consider the person's past wishes and any preferences (particularly when written down) stated by him or her when they had capacity;
- Must take account of the beliefs and values that would have been likely to influence the person's decision had they had capacity;
- Must, if practical and appropriate, consult anyone previously named by the patient as someone who should be consulted, any carers, anyone who has a relevant lasting power of attorney – a 'donee' (remembering that there are two kinds of LPA – (i) personal welfare, and (ii) property and affairs), and any appointed court deputy about their views concerning what would be in the person's best interests.

Protection from liability offered by Section 5 of the Mental Capacity Act

The MCA provides legal protection for people who need to intervene in the lives of people who lack capacity so that they are able to make a decision on that person's behalf, or provide the care the person needs, as long as they have a reasonable belief that the person lacks capacity to make the particular decision and they are working in the person's best interests.

Generally, however, protection is available as long as:-

- Reasonable steps have been taken to gain permission from the person concerned;
- The decision maker is reasonably sure the person lacks the capacity to make a particular decision;
- The decision maker is working in their best interests, and before making the intervention you have considered whether there is a 'less restrictive' option than the one proposed, and only ruled it out because it is less effective than the one you are now taking;
- Restraint if needed, is a proportionate response to the risk of harm if no action is taken;
- The action doesn't amount to a deprivation of liberty, or conflict with an advance decision made by the person, their LPA or a Deputy;
- The decision maker is spending money to buy goods or pay for services that are in the person's best interests and appropriate authority has been sought.

In a medical context, this could be helpful on a day-to-day basis, or to deal with an emergency situation where the Mental Health Act does not apply as illustrated in the example, taken from the Code of Practice, in box 3 below.

Box 3 Example: You are called for advice by a local GP. She is with a patient in her home and the ambulance service is in attendance. The patient is dehydrated, and has a suspected UTI (urinary tract infection). The patient has become angry and belligerent at the idea that she needs admission to hospital and is refusing to go. She says that the doctor is in league with her neighbours and they intend to defraud her of her savings the moment she is out of the house. The ambulance staff refuse to intervene because they say it would contravene the woman's human rights. The GP is considering asking for a Mental

Health Act assessment. She says that, because of the advanced age and presentation of the patient, it is too risky to leave her at home. She confirms that she feels the woman lacks the capacity to take the decision about whether or not hospital admission is necessary because of the acute confusional state brought on by the dehydration and UTI.

You are able to advise the GP and the ambulance staff that, in this situation, the Mental Health Act may not be needed as their intervention would be covered by the Mental Capacity Act. The ambulance staff will be covered by sections 5 and 6 of the MCA, as long as their use of force in taking the woman to A&E is proportionate to the risks that staying at home poses to her.

Limitations to Section 5 by Section 6 Mental Capacity Act 2005.

It is important to recognise that section 5 of the Act does not offer practitioners total freedom from liability in providing care or treatment.

- **Life-changing events:** decisions about life-changing events, such as *changes in residence and serious medical treatment* will only be covered under Section 5 if the decision makers firstly consult all appropriate parties, and secondly consider whether there is a less restrictive way in which the care needed can be given. If there are no families or friends that professionals can consult in these specific circumstances, or if the decision maker deems the family member or friends “inappropriate”, an Independent Mental Capacity Advocate (IMCA) must be instructed to support and represent the person whilst their best interests are being determined.
- **The use of force, and depriving people of their Liberty:** doctors and other professionals will continue to be protected by the law where, in an urgent situation, it is necessary to restrain or restrict a person who lacks capacity in order to protect them from harm. The force used must be proportionate to the risks involved. However, this protection has a ‘time limit’. Where restraint is needed on an ongoing basis (and restraint can mean the use of medication, or making a decision or making it known to a patient that they would be prevented from leaving) professionals involved won’t necessarily be protected by the MCA – this is where the Deprivation of Liberty Safeguards become important.

Advance decisions to refuse medical treatment

People can now make advanced decisions to refuse treatment, provided that the decisions were made when the person had the capacity to make them.

To make a valid advance decision, a person must:

- Be 18 years or older
- Have capacity to make the specific decision
- Make a decision that is applicable (i.e. specific to the care and treatment they want to refuse and the circumstances in which it will be refused)

The decision doesn’t need to be in writing, unless it relates to life sustaining treatment – in which case it must be in writing, and witnessed.

An advanced decision becomes valid and applicable when all of the conditions described within it are present.

If Doctors are not informed about the existence of an advanced decision then they are expected to treat someone with that person’s best interests in mind.

Lasting Powers of Attorney and Deputies from the Court of Protection

The MCA allows people to make arrangements for others to make decisions on their behalf when or if they lack 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. The Act also allows people to empower an attorney to make health and welfare decisions, as well as financial & property decisions (a LPA for finance and property can be used whilst a person still has capacity, if the donee gives specific instruction). Before it can be used a LPA must be registered with the Office of the Public Guardian (see below).
- **Court appointed deputies** – The Act provides for a system of court appointed deputies to replace the previous system of receivership in the “old” 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.

- **A Court of Protection** – The new Court has jurisdiction relating to the whole Act. It has its own procedures and nominated judges. It is 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 deals with decisions concerning both property and affairs, as well as health and welfare decisions.
- **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. The OPG runs three registers for Lasting Powers of Attorney, Enduring Powers of Attorney and Deputies; this information is available to members of the public. The OPG 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.
- **Independent Mental Capacity Advocate (IMCA)** – An IMCA is someone instructed to support a person who lacks capacity but has no one to speak for him or her, such as family or friends, or if family or friends are present but considered “inappropriate” to assist in the process. IMCAs must be involved where decisions are being made about serious medical treatment or a change in the person’s accommodation where it is provided, or arranged, by the National Health Service or a local authority, and may be involved in abuse cases. 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; challenges can be made via the Court of Protection or Judicial Review process. However, it is still up to the decision

maker to consider what they believe is in the person’s best interests.

Key Concepts for doctors:

- Lack of capacity in one area can’t be assumed to mean lack of capacity in another – and patients should be as involved as possible in all decisions made about their treatment.
- Where it is proposed that a person move permanently into residential or nursing care, or serious medical treatment is proposed for someone who lacks capacity, the person’s relatives must be consulted about what they believe the person’s views about this would be, and whether the move or treatment would be in their best interest. If there are no relatives, an IMCA must be consulted.
- The MCA s5 protects staff from liability as long as they have a reasonable belief that a person lacks capacity, and any force used in an urgent situation is proportionate to the risks that would fall to that person if they were not restrained. Where care needs to be provided in such a restricted way that it amounts to a ‘derivation of liberty’, this needs to be authorised. From April 09, the Deprivation of Liberty Safeguards may provide the authority needed to detain someone that is unable to consent to care or treatment being provided in a registered care home or hospital setting. (The Deprivation of Liberty Safeguards are the Government’s response to the European Court of Human Rights’ requirement that the so called “Bournewood Gap” be dealt with in British Law.)
- Where staff become aware that a patient has made an advance decision refusing a particular treatment, that refusal has the same force as if the patient were making it contemporaneously, i.e. the medical treatment could not be given unless the doctor concerned was happy either that the patient did not have capacity when the decision was made, or that they did not intend the decision to have effect in the current circumstances.

Conclusion.

Anecdotally, medical practitioners appear to have been slow to make use of the powers and safeguards provided by the MCA. Relatively small numbers of referrals have been made to the IMCA services

nationally to support those people that lack capacity and are “unbefriended” in the decision making processes around serious medical treatment. Only 671 eligible referrals were received by IMCA services in England and Wales in 2007/2008. (First Annual Report of the IMCA Service, July 2008). Could it be that an assumption is being made that the IMCA service may be seen more of a hindrance than a help, rather than a safeguard for the patient, in providing care and treatment?

The Act requires professionals to “presume capacity” rather than incapacity, for most professionals this is a challenge that we often fail to meet. It is easier to work with a presumption of incapacity and to act in that person’s best interest rather than take the time to “evidence” their capacity in relation to a variety of decisions that may need to be made.

The Act’s two new criminal offences have resulted in a small number of prosecutions to date. These prosecutions have tended to be brought against staff providing care in care homes or domiciliary settings rather than in hospital or other medial settings.

Does this mean that staff working in hospitals or medical settings provide better care?

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COMPETING INTERESTS

None Declared

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