Overview: The Mental Capacity Act 2005

Over two million people in England and Wales lack mental capacity to make some decisions for themselves and the vast majority of these people are from the geriatric population. Following on from last month's article on the related Bournewood proposals, **Drs Shirish Bhatkal** and **Nusrat Khan** discuss the impact and practicalities of the Mental Capacity Act 2005 implemented this month.

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The Mental Capacity Act 2005[1] is being implemented in April 2007. This Act clarifies the legal uncertainties that arose from existing common law regarding consent to medical treatment. It deals with decisions relating to people who lack mental capacity and are unable to act autonomously. The Act sets out five basic principles. There is an assumption of capacity unless proved otherwise. All practical steps should be taken to help a person make a decision before treating them as incapable and a person should not be treated as incapable of making a decision because his/her decision may seem unwise. Decisions made or actions taken for people that lack capacity should be done so in their best interests and in the least restrictive way.

There is now a statutory definition of capacity, assessment of capacity is decision specific and the Act sets out the best practice approach to determine capacity. The test for assessing capacity essentially remains the same as before; they must be able to understand the information relevant to the decision, retain that information and be able to use it as part of the process of making the decision. The need to believe the decision has been removed and the need to be able to communicate that decision to others has been added. All decisions should be made in the best interests of the person and, although the Act does not give a definition, it does provide a checklist.

Prior to the Mental Capacity Act 2005, there were no statutory powers for 'proxy consent' in English Law. Now, the Act provides two routes of obtaining proxy consent to treatment in cases where an adult does not have capacity — the lasting power of attorney (LPA) and court-appointed deputy (CAD). The Act now allows people with capacity to appoint a LPA who can deal with property and affairs replacing the current enduring power of attorney. Unlike previously, a LPA can also be appointed to make health and welfare decisions. For people who lack capacity and have not appointed LPA or made an advance decision refusing treatment, the person providing care or treatment decides what is in their best interests. If necessary an application can be made to the Court of Protection. The Court of Protection can then either make a one-off decision or, in complex cases, appoint a CAD who will make decisions in the person's best interests. Under the new statutory provisions the treating clinician will be under the duty to seek consent from these individuals. The appointment of a deputy to manage a person's property and financial affairs is likely to be needed in similar circumstances to those that previously governed the appointment of the receiver under the Part VII of the Mental Health Act 1983[2] (which this Act repeals). It is expected that the appointment of a deputy to make personal welfare or healthcare decisions is likely to be needed only in the most difficult cases, when necessary action cannot be

Key points

- Assessment of capacity is decision specific and the Act sets out the best practice approach to determine capacity.
- The Act now gives statutory force to advance decisions to refuse treatment.
- The LPA can also be appointed to make health and welfare decisions.
- For people that lack capacity and have no-one other than paid carers to consult, independent mental capacity advocate (IMCA) should be appointed when decisions are being made about serious medical treatment or significant changes of residence.
- Under the Act there is now a new criminal offence of ill treatment or neglect against those that lack mental capacity.

taken without formal powers and/or there is no other way of making a decision in the best interests of the person lacking capacity[3].

The Act now gives statutory force to advance decisions to refuse treatment, including refusal of life-sustaining treatment, but the latter must be in writing and witnessed. It does not allow someone to demand specific forms of treatment. Advance decisions made while one has capacity allows someone to refuse specified medical treatment in advance. The Mental Capacity Act does not apply to treatment being given under part IV of the Mental Health Act, and so advanced decisions to refuse treatment for mental disorders can be overruled if someone is subject to compulsory treatment under the Mental Health Act 1983. Treating clinicians can provide treatment if there is any doubt about the validity or applicability of an advance decision. If there are any uncertainties regarding the advance decision the clinician can approach the Court of Protection, which has emergency provisions and are contactable 24 hours a day.

For people that lack capacity and have no one other than paid carers to consult, the local authorities or NHS bodies have a legal responsibility to appoint an independent mental capacity advocate (IMCA) when decisions are being made about serious medical treatment or significant changes of residence. Much of the detail as to how the IMCA service will operate is not contained in the Act itself, but will instead be contained in Regulations made under the Act.

Currently under the Act the role of the IMCA would include: representing and supporting the person, obtaining and evaluating information, ascertaining the person's wishes and feelings, ascertaining alternative courses of action and obtaining a further medical opinion, if necessary. The Act also creates the Office of the Public Guardian (OPG), which replaces the Public Guardianship Office. This office maintains a register of LPAs and deputies. It also will co-ordinate with other agencies to supervise deputies and investigate complaints.

Also contained within the Act are provisions for research and introduction of a new criminal offence. The Act now sets out new safeguards for research that involves incapacitous individuals — research that must be approved by an appropriate body. Under the Act the researcher must take reasonable steps to identify someone (the consultee) who is engaged in caring for the person. The consultee must give permission for the research to go ahead and can withdraw the person from the research, if felt appropriate. There is now a new criminal offence of ill treatment or neglect against those that lack mental capacity.

A draft code of practice has been published to aid interpretation of the Act and the Department of Health have issued new proposals to address the 'Bournewood gap'[4] (*see GM March 2007 page 37*) referring to the situation whereby people who lack capacity to consent are treated informally in circumstances that amount to a deprivation of liberty. As geriatricians' contact with people that lack capacity is frequent, knowledge of the new statutory provisions for such people is imperative.

Conflict of interest: none declared.

References

1. The Mental Capacity Act 2005, http://www.opsi.gov.uk/acts/acts2005/50009--b.htm#30
2. The Mental Health Act 1983
3. The Mental Capacity Act 2005, Draft Code of Practice. http://www.dca.gov.uk/consult/codepractise/draftcode0506.pdf
4. Bournewood Briefing Sheet, June 2006. Department of Health