

## Executive Briefing The Mental Capacity Act

### **The Mental Capacity Act 2005 is underpinned by five key principles:**

- every adult should be assumed to be capable of making their own decisions unless proved otherwise
- everyone should be given all the support they need to make their own decisions, before they are judged incapable of doing this
- people should be able to make 'eccentric' or 'unwise' decisions – it is their capacity to make decisions, not the decisions themselves, that is the issue
- anything done for or on behalf of people without capacity must be in their best interests
- anything done for or on behalf of people without capacity should restrict their rights and freedoms as little as possible.

### **The Mental Capacity Act**

The Mental Capacity Act 2005 for England and Wales will come into force in 2007 (Scotland has its own Adults with Incapacity (Scotland) Act 2000.) It will affect everyone aged over 16 whose mental capacity is in doubt.

### **The background and need for the Act**

Mental capacity' means a person's ability to make a decision about some aspect of their lives. Mental capacity can be affected by a learning disability, mental health problems, dementia, stroke and other conditions. The Act aims to protect the rights of people whose mental capacity is in doubt, and people without mental capacity and clear up confusion about who is entitled to make decisions on behalf of the latter. The Government's initial research suggests that this may be around 1.2 million people in England and Wales. With more people with severe disabilities living into adulthood and more people living into old age, this number will almost certainly increase.

Until now, there has been little legal protection in the area of mental capacity. Save where the acts are clearly unlawful, it has been difficult to challenge people who are suspected of abusing someone by making decisions on their behalf, for example when in fact the person does have capacity, or when the person does not have capacity, making decisions that are not in the person's best interests. On a day to day level, carers and professionals have frequently been in a very difficult position when it is necessary to make a decision for someone without capacity because they are

not clear on the law. For example, medical professionals have not been clear about whether they should abide by decisions patients made about their treatment before they lost capacity.

There has also been an insufficient understanding that while a person may lack capacity to make complex decisions, such as agreeing to a medical operation, they could have the capacity to make day to day decisions; or that people's capacity may fluctuate so that while sometimes that are not capable of making decisions for themselves they may be able to do so at other times.

### **What the new legislation will mean Mental capacity**

The capacity to make decisions can relate to day to day choices of what to wear or eat to more difficult choices about housing, medical treatment or personal finances. It does not matter if other people would not agree with the decision but it does require the person to understand a situation and understand what will happen if they take a particular decision about it. The Act states that a lack of capacity can be either temporary or permanent, but must relate to some form of disturbance in the functioning of the mind or brain.

### **Assessing capacity**

The Act states that everyone is assumed to have the capacity to make decisions for themselves unless shown otherwise. If it is not clear whether someone has the

capacity to make a decision concerning a specific issue an assessment of their capacity should be carried out.

The professionals, families and other carers (paid and unpaid) involved in assessing someone's capacity will do this on a 'decision-specific' basis, which looks at the person's ability to make a particular decision at a particular time, and the person's ability to understand the relevant information as well as the consequences of their decisions.

Those making decisions on behalf of another person have to reasonably believe that the person does not have capacity, having taken reasonable steps to assess the person's capacity. They cannot decide that someone does not have capacity just because of the way the person looks or behaves, or because the person has difficulties communicating – although the person does need to be able to communicate their decision in some way, with help if necessary.

If the person's capacity to make decisions varies at different times, this should be taken into account as well. For example, if it is thought that the person will have capacity to make the decision in the future, then, if it can be delayed, the decision should be put off until the person can make it for him/herself.

### **Making decisions for people who lack capacity**

Professionals, families and other carers will be able to make decisions on behalf of someone whose lack of capacity has been established as long as these decisions are in the person's 'best interests'. This includes decisions involving actions which might otherwise be considered to 'interfere' with the person's body or property, such as providing personal care, or entering someone's house to perform an essential domestic task. However, decisions about marriage, sexual relationships, adoption or voting can never be made on behalf of another person.

Even if a person lacks capacity they must be given the opportunity to take part as fully as possible in any decision that affects them.

### **Best Interests**

In considering what is in the person's best interests the decision-maker must take into account a checklist of factors. This includes considering everything known about the person's feelings, beliefs and values and consulting those concerned with the person's welfare. This means that professionals must, so far as possible, consult relatives and carers and take their views on what is in the person's best interests into account. If the person had made a statement, particularly if this is in writing,

before they lost capacity, in which they set out how they would like to be cared for this must also be considered (an 'advance statement').

### **Advance Directives**

Adults with capacity can make an advance decision about medical treatment in which they specify that they do not want to be given certain treatment(s) in the future (known as 'advance refusals' or 'advance directives'). However, if this decision means refusing 'life-sustaining' treatment it must be made in writing including the statement 'even if life is at risk', and signed and witnessed.

### **Advocates and attorneys**

People without capacity who do not have family or friends to support them will be appointed an Independent Mental Capacity Advocate (IMCA) to represent their wishes, feelings, beliefs and values in relation to decisions which need to be made about serious medical treatment, or a placement in NHS or local authority accommodation. The final details of the IMCA service are still being worked out, but the Government has already allocated £6.5 million to pay for it.

People who have capacity can appoint someone under a 'Lasting Power of Attorney' (LPA) to take decisions about property, financial affairs, health and welfare (including decisions about life-sustaining treatment) when they lose capacity in the future. This will replace the existing system of 'Enduring Power of Attorneys' (except for those who have already made one), which do not cover health or welfare issues.

### **Research**

Families and other carers or nominated third parties must be consulted about any proposal to carry out research which involves the person without capacity. A research ethics committee must agree that this research is safe, is appropriate to the person without capacity, and cannot be done as effectively using people who are in a position to give consent. The research must either benefit the person without capacity directly, in a way that outweighs the risks, or be carried out in a way which poses them minimal risk and intrusion. If the person shows any reluctance to take part the research must be stopped immediately.

### **Legal Safeguards**

The Act establishes a new specialised 'Court of Protection' which will deal with issues relating to the management of property and affairs and serious decisions affecting the

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healthcare and/or welfare of individuals who lack capacity. It will also be able to determine the capacity of an individual where this is in doubt. The Court will have the final say on any disputed matters. The Court can appoint 'deputies' to act and make decisions on behalf of people who lack capacity (although deputies cannot refuse life-sustaining treatment).

A new Public Guardian will, in co-operation with other public agencies, supervise court-appointed deputies and attorneys acting under LPAs

Threatening or using force to restrain someone without capacity is only permissible to prevent harm. There is a penalty of imprisonment for up to five years for anyone found guilty of ill-treating or neglecting a person in their care who lacks capacity.

### Codes of Practice

Guidance on the Act will be provided in the 'Codes of Practice'. All professionals and paid carers must follow this guidance unless there is a good reason for not doing so, and any failure to do so would be considered by the courts in any relevant legal proceedings. Although this legal duty does not apply to relatives and other unpaid carers, they are also expected to follow the Codes.

### Mental Health Foundation concerns and comments

#### Numbers

The Government estimate of the numbers of people directly affected by the Act makes no mention of people with moderate autism spectrum disorder or who are disabled with a stroke, many of whom may have cause to invoke the Act at some point (if only to demonstrate that they do in fact have capacity). This is a potential additional 400,000 people.

### Assessing capacity

Although the Act establishes a definition of capacity and sets out clear principles which must be adhered to when assessing capacity, it does not outline in detail the process which everyone should follow in carrying out an assessment. It is essential that those assessing capacity understand what is involved so that the principles of the Act are upheld in practice; for example the fact that someone intends to make a decision that others would disagree with is not in itself evidence of incapacity. The Codes should contain detailed guidance on assessing capacity and it will therefore be crucial that all those involved in this are made aware of such guidance, through training and accessible information, although it is highly

unlikely that family members and other unpaid carers will receive any formal training on the Act and Codes.

### Making decisions for people who lack capacity

As mentioned above, it is unlikely that family or other unpaid carers will receive any training on the Act or Codes. Given that in most cases the day to day decisions on behalf of individuals who lack capacity will be made by their family carers it will be crucial that the general public are made aware of the Act and information is made widely available so that family carers can obtain clear and concise information on their responsibilities. Such information about the Act and Codes must be made available, and produced in all the different formats disabled people need, as well as in different languages.

There are also some concerns about decision-making by family and unpaid carers. It may be difficult to challenge people who either ignore the decision-making ability of a family member who might lack capacity, or make decisions which are not in that person's best interests, if they are that person's main, or sole carer and potential decision-maker. Where advocates, professionals and paid carers are also involved they will have an important role to ensure this does not happen.

### Lack of clarity in role of IMCAs

The Foundation is one of many organisations which believe that IMCAs should not be restricted to people who are found to lack capacity and have no other unpaid support. Ideally, advocacy should be available for everyone who lacks capacity, as well as for those people whose capacity is being assessed – especially since many people who provide support to friends and relatives who lack capacity need help themselves in negotiating statutory health and social care systems.

The Act states that IMCAs will be involved where the provision of 'serious medical treatment' is being proposed. However at present there is no clear definition of this term.

It is also unclear as to how the IMCA service will be organised or how existing advocacy organisations could be involved in providing the service. They may lose funding which goes to newly established IMCA services or they may be expected to fit into the new scheme, and lose some of their independence because of having more statutory duties.

The Government has done a consultation on the IMCA service but the results have not yet been published.

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## The health and social care sectors

The new Act has enormous implications for day to day work as well as for overall policies. Procedures such as the Care Programme Approach, person-centred planning, the single assessment process, and other assessments for services will all need to incorporate the new principles and practice and it will be crucial for all staff involved with these processes to understand what their responsibilities will be under the Act.

The Government has estimated that half a day's training will be sufficient for professionals working in health and social care. This is questionable, especially since a great number of care staff will have to apply the codes to their day to day work (in settings where people without capacity have not always been taken seriously or treated well in the past) and this training only applies to people working in the statutory sector. The new law will definitely have to be covered in the relevant training courses and degrees.

Although the Government has provided for changes in procedures for the health and social care sector in general, a whole range of other bodies (including the General Medical Council, patient representative bodies and research bodies) will also have to review their policy and practice.

## Monitoring and evaluation

The Government is committed to monitoring and evaluating the Act's effectiveness and impact, but this is another area where the detail is not yet clear. It will be important to have a comprehensive review similar to the one which has recently reported on the Scottish legislation.

## Interrelationship with mental health legislation

The relationship between the powers under this Act and the compulsory powers of admission to hospital and treatment for mental disorder are unclear.

The provisions of the Act which allow decisions to be taken 'in connection with the care or treatment' of a person who lacks capacity, include the admission to hospital for treatment for mental disorder. Where this is necessary to prevent harm and it is a reasonable response to such possible harm, restraint may be used (including the use of force and restricting the person's liberty of movement) so long as this does not amount to a 'deprivation of liberty' (within the meaning of the European Convention on

Human Rights). The distinction between these concepts is not clear cut and therefore these provisions could create confusion and concern. Given that individuals who lack capacity but object to their admission to hospital for treatment for mental disorder would need to be admitted under the Mental Health Act 1983 the confusion about the scope of the powers under the Mental Capacity Act may lead to an increase in the use of the Mental Health Act 1983.

Further safeguards are also needed in light of the European Court of Human Rights judgment on the 'Bournewood' case concerning the admission to hospital of someone lacking capacity to consent, where the Court ruled the admission amounted to a deprivation of liberty and the lack of legal safeguards meant that the patient's right to liberty had been breached. In response to this, the Government has indicated that it would like a system of 'protective care', under which it would be possible to detain individuals without capacity to provide care and treatment in the person's best interests, and do this in accordance with the principles and procedures under the Act. However, it is not yet clear what legislation would cover this and further details are awaited.

There remain therefore a number of unresolved questions about the relationship between the two pieces of legislation as well as any new mental health legislation in the future. The 2004 draft Mental Health Bill does not include any assessment of mental capacity except in relation to electro-convulsive therapy. Should people with mental disorders be treated differently from other people covered by the Mental Capacity Act? Are concepts like 'best interest' and 'least restrictive alternative' likely to be interpreted differently depending upon which legislation is deemed to be appropriate? Will advance directives and advance statements, neither of which are recognised in the Mental Health Act, have a status similar to that in the Mental Capacity Act, in any future mental health legislation?

## Conclusion

The new Act is a major step forward in protecting some of the most vulnerable people in our society. Campaigners have pressed for this since 1989; and although many have concerns with the details, it is very welcome. The main concerns are over whether it achieves that protection as effectively as it might.