

The Mental Capacity Act 2005

Guidance for health professionals

March 2007

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Introduction

The Mental Capacity Act 2005 provides a comprehensive framework for decision-making on behalf of adults aged 16 and over who lack capacity to make decisions on their own behalf. The Act applies to England and Wales. Scotland has its own legislation, the Adults With Incapacity (Scotland) Act 2000 for which the BMA has produced a separate guidance note.¹ The approach in Northern Ireland is currently governed by common law.

The Act will be implemented in two stages during 2007. In April 2007, the new Independent Mental Capacity Advocate service (IMCAs) will become operational in England only. All other parts of the Act, including IMCAs in Wales, will come into force in October 2007.²

The Act applies to all decisions taken on behalf of people who permanently or temporarily lack capacity, including decisions relating to medical treatment. All doctors working with adults who lack, or who may lack, capacity will need to be familiar with both its underlying principles and its basic provisions. In general the Act confirms and reinforces best practice, placing the pre-existing common law provisions on a statutory footing, and much of it may therefore be familiar to those with experience working with adults lacking decision-making capacity. There are, however, a number of new features, including the ability to nominate substitute decision-makers under a Lasting Power of Attorney (LPA), the development of a new Court of Protection with extended powers, and specific provisions for enrolling incapacitated adults in certain forms of research. This guidance note sets out the main features of the Act in so far as it relates to decisions about medical treatment. Further guidance is available from the Department of Health and in the Mental Capacity Act's Code of Practice.³ More detailed guidance on the assessment of mental capacity can be found in the joint BMA/Law Society publication *Assessment of Mental Capacity*.⁴

What is capacity?

Decision-making capacity refers to the everyday ability that individuals possess to make decisions or to take actions that influence their life, from simple decisions about what to have for breakfast, to far-reaching decisions about serious medical treatment. In a legal context it refers to a person's ability to do something, including making a decision, which may have legal consequences for the person themselves or for other people.

When does a person lack capacity?

Although the concept of capacity is inevitably complex, for the purpose of the Act a person lacks capacity if, at the time the decision needs to be made, he or she is unable to make or communicate the decision because of an 'impairment of, or a disturbance in the functioning of, the mind or brain'.⁵ The Act contains a two-stage test of capacity:

- Is there an impairment of or disturbance in the functioning of, the person's mind or brain? If so,
- Is the impairment or disturbance sufficient that the person lacks the capacity to make that particular decision?

The assessment of capacity is also 'task-specific', that is to it say focuses on the specific decision that needs to be made at the specific time the decision is required. It does not matter therefore if the incapacity is temporary, or the person retains the capacity to make other decisions, or if the person's capacity fluctuates. The inability to make a decision, however, *must* be a result of the impairment or disturbance already mentioned. This could be the result of a variety of factors, including mental illness, learning disability, dementia, brain damage, or intoxication. The important point is that the impairment or disturbance renders the individual unable to make the decision in question. Clearly, however, if the impairment is temporary and the decision can realistically be put off until such a time as he or she is likely to regain capacity, then it should be deferred. While it is clear that an unconscious patient will lack capacity, most other categories of patient will retain some decision-making capacity, however slight.

Basic principles

The Act sets out a number of basic principles that must govern all decisions made and actions taken under its powers. These are rooted in best practice and the common law and are designed to be fully compliant with the relevant sections of the Human Rights Act. Where confusion arises about how aspects of the Act should be implemented, it can be extremely helpful to refer back to them. Actions or decisions that clearly conflict with them are unlikely to be lawful, although there may be occasions on which they are in tension with each other, and some balancing will be required. A list of the principles, with brief descriptions is given below. Further information about some of these principles comes later in the guidance note.

A presumption of capacity

It is a fundamental principle of English law that adults have the right to make decisions on their own behalf and are assumed to have the capacity to do so, unless it is proven otherwise. The responsibility for proving that an adult lacks capacity falls upon the person that challenges it. This clearly echoes one of the main ethical principles governing medical practice, the respect for autonomy.

Maximising decision-making capacity

Closely linked to the presumption of capacity, this states that everything practicable must be done to support individuals to make their own decisions, before it is decided that they lack capacity. The aim is to ensure that individuals who are capable of making decisions for themselves, but may need some support, are not inappropriately assessed as incapacitated.

The freedom to make unwise decisions

The fact that an individual makes a rash, unwise or irrational decision, or begins to act out of character, is not itself proof of incapacity. Such actions may raise questions about capacity – where for example they follow a period of illness or an accident – but they are in no way determinative.

Best interests

At the heart of the Act lies the principle that where it is determined that an individual lacks capacity, any decision or action taken on his or her behalf must be in his or her best interests. Practically speaking, what constitutes an individual's best interests will depend upon the circumstances of each individual case.

The least restrictive alternative

Whenever a person is making a decision on behalf of an adult who lacks capacity, he or she must ensure that the decision is the least restrictive of that individual's fundamental rights or freedoms. There are often several ways to achieve a desired outcome, and the choice must be the one that interferes least with the individual's freedoms while still achieving the necessary goal.

Who should assess capacity?

The person who wishes to make a decision on behalf of an incapacitated person is responsible for assessing his or her capacity. Where consent to medical treatment is required, the health professional proposing the treatment needs to decide whether the patient has the capacity to consent. The reasons why capacity are in doubt should be recorded in the medical record, as should details of the assessment process and its findings. The more serious the decision, the more formal the assessment of capacity is likely to be, and, where appropriate, it might be advisable to refer to a psychiatrist or psychologist for a second opinion.

How do you assess capacity?

Although the Government suggests that the Act contains a 'single clear test for assessing whether a person lacks capacity to take a particular decision at a particular time,'⁶ the reality of clinical practice is always likely to be slightly more complex. The Act nevertheless makes use of a 'functional' test of capacity, adapted from the common law, which focuses on the decision-making process itself. Under the Act, a person is regarded as being unable to make a decision if, at the time the decision needs to be made, he or she fails:

- To understand the information relevant to the decision
- To retain the information relevant to the decision
- To use or weigh the information, or
- To communicate the decision (by any means)

Where an individual fails one or more parts of this test, then they do not have the relevant capacity and the entire test is failed.

Clearly difficult judgements will still need to be made, particularly where there is fluctuating capacity or where some capacity is demonstrable but its extent is uncertain. This four stage test is nevertheless well established, and more detailed advice on practical procedures for assessing capacity is available from other sources.⁷ The Act requires that any decision that a person lacks capacity must be based on a 'reasonable belief' backed by objective reasons.

Where there are disputes about whether a person lacks capacity that cannot be resolved using more informal methods, the Court of Protection can be asked for a judgement.

A refusal to be assessed

Occasionally an individual whose capacity is in doubt may refuse to be assessed. In most cases, a sensitive explanation of the potential consequences of such a refusal, such as the possibility that any decision they may make will be challenged at a later date, will be sufficient for them to agree. However, if the individual flatly refuses, in most cases no one can be required to undergo an assessment.

Best interests

At the heart of the Act, and, arguably, first amongst its principles, lies the fundamental tenet that all decisions taken on behalf of someone who lacks capacity must be taken in his or her best interests. Once again this is a statutory codification of the existing common law position, and gives the Act its moral compass. Given the variety of interventions that can be covered by the Act, it understandably avoids a definition of best interests, giving in its place a statutory checklist of common factors that must be taken when such a judgement needs to be made. A best interests judgement is not a 'substituted judgement' test, not an attempt to determine what the person would have wanted, although this must be taken into account. It is instead as objective a test as possible of what would be in the person's actual best interests, taking into consideration all relevant factors. In accordance with the Act's underlying principles, an individual must be permitted, as far as possible, to participate in the decision-making process. The decision-maker must also take into account the likelihood that the person will regain capacity. If a decision can reasonably be left until he or she regains capacity, then, as already mentioned, it should be. Other relevant factors are likely to include:

- The person's past and present wishes and feelings, including any relevant written statement made when she or he had capacity – this would include general statements of wishes or 'living wills'
- His or her beliefs or values where they would have an impact on the decision.⁸

A crucial part of any best interests judgement will involve a discussion with those close to the individual, including family, friends or carers, where it is practical or appropriate to do so. It could also include anyone nominated to act under a LPA or any deputy appointed to make decisions by the Court of Protection. Further information about the last two is given later in the guidance.

Acts in connection with care or treatment

Under common law, it has been clear that where an adult lacks capacity to make decisions on his or her own behalf, health interventions will be lawful where there is both a necessity to act, and any action is in the best interests of the incapacitated adult.⁹ The Act clarifies this aspect of common law by giving legal protection to decision-makers in these circumstances. An action or intervention will be lawful – ie health professionals will enjoy protection from liability – where the decision-maker has a *reasonable belief* both that the individual lacks capacity, and that the action or decision is in his or her best interests. It applies to anyone making a decision on behalf of another, irrespective of whether they have a professional relationship with the incapacitated

individual. It could include, for example, taking an incapacitated stranger by the arm to assist them cross a road. In relation to medical treatment, it is applicable not only to an episode of treatment itself, but also to those necessary ancillary procedures such as conveying a person to hospital.

There are limits to these powers however. A valid advance decision, and a valid decision by an attorney or a court appointed deputy would take precedence. The Act also sets limits to the extent to which the freedom of movement of an incapacitated person can be restricted. An incapacitated person can only be restrained where there is a reasonable belief that it is necessary to prevent harm to the incapacitated person. Any restraint must also be in accordance with the underlying principles mentioned earlier – it must be proportionate to the risk, and of the minimum level necessary to protect the incapacitated person.

Although reasonable use of restraint may be lawful, the Act makes it clear that it will never be lawful to deprive a person of his or her liberty within the meaning of Article 5(1) of the European Convention on Human Rights. The onus is on the person wishing to act to objectively justify his or her belief that the person being cared for is likely to be harmed unless some sort of physical intervention or other restraining action is taken. The significance of this point was established by the European Court of Human Rights judgement in the ‘Bournewood’ case,¹⁰ which held that a voluntary incapacitated patient had been unlawfully detained after having been admitted into hospital under the common law doctrine of necessity.

The ‘Bournewood’ case

The Bournewood case concerned an autistic man with severe learning disabilities who was informally admitted to Bournewood Hospital under common law. The European Court of Human Rights found that he had been deprived of his liberty unlawfully without a legal procedure with safeguards and rapid access to a court of appeal. The Court made it clear that the question of whether someone has, in fact, been deprived of liberty depends on the particular circumstances of the case.

The Government has used the Mental Health Act 1983 Amendment Bill to amend the Mental Capacity Act in relation to detained voluntary incapacitated patients. Where a care home or hospital identifies that a person who lacks capacity is being, or risks being, deprived of their liberty, they must apply to a ‘supervisory body’ for authorization of the deprivation of liberty. Where a person is in a care home the supervisory body will be the relevant local authority. Where the person is in a hospital it will be the relevant PCT, or, in Wales, the National Assembly for Wales. In an emergency, the care home or hospital can itself provide an urgent authorization for a maximum of seven days.¹¹

Before the Act came into force, the courts had decided that some decisions were so serious that each case should be taken to court so that a declaration of lawfulness could be

made. The Act’s Code of Practice advises that the following cases should continue to go before the court:

- Proposals to withdraw or withhold artificial nutrition and hydration from patients in a persistent vegetative state
- Cases involving organ or bone marrow donation by a person lacking the capacity to consent
- Proposals for non-therapeutic sterilization
- Some termination of pregnancy cases
- Cases where there is a doubt or dispute about whether a particular treatment will be in a person’s best interests
- Cases involving ethical dilemmas in untested areas

Withdrawing and withholding life-sustaining treatment

The Mental Capacity Act contains special safeguards in relation to the withdrawing and withholding of life-sustaining treatment in relation to an adult who lacks capacity. The law and ethics of decision-making in this area are beyond the scope of this document. Detailed advice is available in a separate guidance note from the British Medical Association, *Withdrawing and Withholding Life-Prolonging Treatment*.

Advance decisions refusing treatment

Although the legality of valid and applicable advance refusals of treatment has been established at common law,¹² the Act provides welcome statutory clarification. The Act’s powers are restricted explicitly to advance decisions to refuse treatment. Although broader general advance statements or ‘living wills’ which indicate treatment preferences may well be relevant to a broader ‘best interests’ assessment, they are not legally binding. An advance refusal of treatment is binding if:

- The person making the directive was 18 or older when it was made, and had the necessary mental capacity.
- It specifies, in lay terms if necessary, the specific treatment to be refused and the particular circumstances in which the refusal is to apply.
- The person making the directive has not withdrawn the decision at a time when he or she had the capacity to do so.
- The person making the directive has not appointed, after the directive was made, an attorney to make the specified decision.
- The person making the directive has not done anything clearly inconsistent with the directive remaining a fixed decision.

Although advanced decisions can be oral or in writing, an advance refusal will *only* apply to life-sustaining treatment where it is in writing, is signed and witnessed, and contains a statement that it is to apply even where life is at risk. Advanced decisions cannot be used to refuse basic care, which includes warmth, shelter and hygiene measures to maintain body cleanliness. This also includes the offer of oral food and water, but not artificial nutrition and hydration.

In an emergency or where there is doubt about the existence or validity of an advance directive, doctors can provide treatment that is immediately necessary to stabilize or to prevent a deterioration in the patient until the existence or applicability of the advance directive can be established.

Where a patient is subject to compulsory treatment under mental health legislation, an advance refusal relating to treatment provided for the mental disorder for which compulsory powers have been invoked will not be binding, although the treating professional should take such a directive into account. This could include, for example, considering whether there are any other treatment options available that are less-restrictive. An agreed advance treatment plan for mental health conditions can be helpful and would represent a kind of advance statement, although it would not be binding.

Research

One of the Act's significant innovations is its clear statement on the legality of enrolling incapacitated adults in certain, closely regulated, forms of medical research. This clarifies a long-running area of concern amongst health professionals and researchers, and is likely to result in sustained improvement in research related to incapacitating conditions. Excluded from the Act, however, are those clinical trials regulated under the Medicines for Human Use (Clinical Trials) Regulations 2004 (SI 2004/1031). These already permit the carefully controlled enrolment of incapacitated adults in clinical trials relating to pharmaceutical products. A proposed amendment to these regulations allows emergency research in certain circumstances without consent. At the time of writing however this had not come into effect.

In keeping with established international norms in medical ethics,¹³ in order to be lawful, research involving incapacitated adults *must* be related to the condition that contributes to the impairment of the mind or brain from which the incapacitated person is suffering. This includes research into the impact of the impairment on the person's day-to-day health and welfare, as well as into the causes of the impairment and any possible treatments. Any research must be approved by an appropriate body, such as a Research Ethics Committee (REC), and it must not be possible to conduct the research involving individuals who retain the capacity to consent.

Where the research is expected to benefit the individual directly – often called 'therapeutic research' – the risks must not be excessive in relation to the anticipated benefits. Where the research is not expected to deliver direct benefit to the patient, but is intended to investigate the condition from which he or she suffers, the risk to the individual must be negligible, and any intrusion or restriction on the patient's basic rights must be kept to a minimum. This kind of research could include research involving medical notes for example, or investigations into the provision of services.

Before an incapacitated individual can be enrolled in research, the researchers must identify somebody close to them who is willing to be consulted about the appropriateness of his or her involvement. Where they are unable to locate such a person, then they must nominate somebody who is independent of the research. RECs will provide further guidance on this process.

Additional safeguards are in place once the research is underway. Where the incapacitated individual shows signs of distress or resistance, these must be respected, and the

individual withdrawn from the research. Likewise if he or she indicates by any means the wish not to continue to take part in the research, then he or she must be withdrawn. Regulations have also been drawn up under the Act to cater for the management and protection of an adult enrolled in a research project who loses capacity after the research has commenced.¹⁴

The removal of tissue from incapacitated individuals for purposes scheduled under the Human Tissue Act 2004 is covered by the Mental Capacity Act. Further information is available in a separate BMA guidance note, *Human tissue legislation: guidance from the ethics department*.¹⁵

Lasting powers of attorney (LPAs)

Although enduring powers of attorney, which relate to the management of property and affairs, have been on statute since 1985, they are replaced under the Act by LPAs which extend to health and welfare decisions. An individual can nominate another person to make health care decisions on his or her behalf when he or she loses the capacity to make such decisions. This transfer of health decision-making authority has to be indicated in the LPA, and does not extend to refusing life-sustaining treatment *unless* this is explicitly stated. The individual creating the LPA can also set a variety of conditions on the exercise of the powers. Anyone acting under the powers of an LPA is constrained by the basic principles of the Act and has to make decisions in the best interests of the incapacitated person. When a health professional has a significant concern relating to decisions taken under the authority of an LPA about serious medical treatment, the case can be referred for adjudication to the Court of Protection.

Decisions by the Court of Protection and Court appointed deputies

The Act creates a new Court of Protection which is ultimately responsible for the proper functioning of the legislation. The Court is the final arbiter in relation to the legality of decisions made under the Act, including decisions in relation to an individual's capacity. In addition to adjudicating in relation to specific, one-off decisions, the Court will also have the power, where appropriate, to appoint deputies to assist with continued decision-making. These deputies will replace the current system of Court of Protection receivers. Although health care decisions can be lawfully made without a deputy, they can nonetheless be useful where disputes over care and treatment arise. Deputies do not have power under the Act to refuse consent to life-sustaining treatment, nor can a deputy override a decision made by a person appointed by the incapacitated person as an attorney. Where concerns arise about whether an attorney acting under an LPA is making decisions in the best interests of the patient then the Court of Protection can adjudicate.

A new Public Guardian

The Act creates a new Public Guardian which will have responsibility for the registration and supervision of both LPAs and Court appointed deputies. They will also support the Court by providing information to assist in its decision-making.

Independent mental capacity advocates

Another of the Act's innovations is the development of an independent advocacy scheme to support particularly vulnerable incapacitated adults – most often those who lack any other forms of external support – in making certain decisions. Where it is clear that a decision needs to be made on behalf of an incapacitated adult in relation to either serious medical treatment or place of residence and there is no one close to the adult to provide advice or guidance, including an attorney or deputy, then the services of an independent advocate will be engaged. Serious medical treatment is defined as treatment which involves providing, withdrawing or withholding treatment in circumstances where:

- in the case of a single treatment being proposed, there is a fine balance between its benefits to the patient and the burdens and risks it is likely to entail for him or her,
- in a case where there is a choice of treatments, a decision as to which one to use is finely balanced, or
- what is proposed would be likely to involve serious consequences for the patient.

Interface with mental health legislation

As already mentioned, advance directives relating to treatment provided under mental health legislation are not necessarily binding. Having said this, a valid and applicable advance directive for treatment for conditions that are not covered by compulsory powers will apply in the ordinary way. Similarly, where an incapacitated adult is subject to compulsory powers, all other decisions relating to the general care and treatment of the individual will be covered by the Mental Capacity Act.

There may be circumstances in which either legal framework may apply, and the question of which Act to choose will be for the judgement of individual professionals. However, if the treatment is for a physical condition, then mental health legislation is irrelevant. If the treatment is for mental disorder and the patient retains capacity, the Mental Capacity Act cannot be used. Where detention is deemed necessary, mental health legislation must be used, provided the relevant grounds are met.

For further information about these guidelines, BMA members may contact:

askBMA on 0870 60 60 828 or



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- 1 British Medical Association. *Medical treatment for adults with incapacity: guidance on ethical and medico-legal issues in Scotland*. London: BMA, 2002. Available at: <http://www.bma.org.uk/ap.nsf/Content/AdultsincapacitySC>.
- 2 The full implementations timetable is as follows. In April 2007, IMCAs will be introduced in England only. The new criminal offence of ill treatment or wilful neglect will come into force in England and Wales. Sections 1-4 of the Act (the principles, assessing capacity and determining best interests) which are essential to how IMCAs run will also come into force but only in situations where an IMCA is to be involved, and for the criminal offence. Sections 1-4 of the Act will not apply in any other situations until October 2007. The Code of Practice for the Act is due to have completed its Parliamentary passage in April 2007 at which point it will be issued for information and guidance. From this time, in England, those staff involved in statutory best interest decisions where IMCAs have been instructed, will be required to have regard to the Code. It will also provide guidance on the criminal offence. All other parts of the Act come into force in October 2007, including IMCAs in Wales.
- 3 <http://www.dca.gov.uk/menincap/legis.htm#codeofpractice>.
- 4 British Medical Association and Law Society. *Assessment of Mental Capacity: Guidance for Doctors and Lawyers*. London: BMJ 2004.
- 5 Mental Capacity Act 2005. s2(1)
- 6 Department of Constitutional Affairs. *Mental Capacity Act 2005 – summary*. P.1. <http://www.dh.gov.uk/assetRoot/04/10/85/96/04108596.pdf>.
- 7 British Medical Association and The Law Society. *Assessment of Mental Capacity*. London: BMJ Books, 2004.
- 8 Mental Capacity Act 2005. s4(5)
- 9 See *inter alia* *F v West Berkshire Health Authority* [1989] 2 All ER 545
- 10 *HL v United Kingdom* [2004] ECHR
- 11 Further information will be available in the final version of the Code of Practice.
- 12 See *HE v NHS Trust A and AE* [2003] EWHC 1017 (Fam)
- 13 See, for example, World Medical Association. *Declaration of Helsinki*. Ferney-Voltaire, WMA: 1964-2004. <http://www.wma.net/e/policy/b3.htm>.
- 14 Mental Capacity Act 2005 (Loss of Capacity During Research Project) (England) Regulations 2007. <http://www.opsi.gov.uk/si/si2007/draft/20075590.htm>. Mental Capacity Act 2005 (Loss of Capacity During Research Project) (Wales) Regulations 2007. http://newydd.cymru.gov.uk/docrepos/40382/dhss/4038226/The_Mental_Capacity_Act_2002.pdf?lang=en.
- 15 <http://www.bma.org.uk/ap.nsf/Content/Humantissue>.