

The Mental Capacity Act was introduced 10 years ago to ensure capacity to make decisions is properly assessed and those lacking it are well cared for. Is it working?

MENTAL CAPACITY: PART 1 OF 2

Is the Mental Capacity Act fulfilling its aims?

In this article...

- Gaps in care before the Mental Capacity Act 2005 was enacted
- What the MCA aimed to achieve
- The extent of the MCA's success in practice

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Abstract Taylor H (2015) Mental capacity 1: Is the Mental Capacity Act fulfilling its aims? *Nursing Times*; 111: 26, 14-17. The Mental Capacity Act 2005 (MCA) gave nurses caring for people with impaired capacity to make decisions, a framework within which to work and made provision for when patients cannot consent to their care. The act should have taken away the uncertainty associated with caring for patients who lack capacity but evidence suggests it has not yet fulfilled its aims. Part 1 of this two-part series discusses the factors that drove the development of the MCA and explores to what extent its aims have been fulfilled. Part 2 will consider possible reasons for this, and offer recommendations for practice and education.

The Mental Capacity Act 2005 (MCA), which came into effect in England and Wales in 2007, was drafted in response to a growing recognition of the inadequate legal framework governing situations in which people either lacked or had impaired ability to make decisions. It aimed to address a range of complex legal, social and healthcare issues. By reviewing its implementation in legal and healthcare practice, this article considers the extent to which the MCA has fulfilled its key objectives, focusing on three issues that

are fundamental to nurses providing routine patient care:

- » The presumption of capacity;
- » Defining incapacity;
- » How to make decisions when patients are unable to give their consent.

Historic overview

The National Health Service and Community Care Act, passed in 1990, reflected a new and evolving ethos of the NHS as an enabler, rather than a provider, of care (Griffiths, 1988). Traditionally, people with a range of learning disabilities and mental ill health were cared for as long-term residents in hospital, with little or no control over their daily lives; this was no longer considered appropriate and the focus shifted to giving people the support they needed to live independent, autonomous lives (Department of Health, 1989). As a result, large numbers of people – some of whom had lived in long-stay care institutions for much of their lives – made what was often a very sudden transition to community care.

Some individuals were presented with challenges they had not previously encountered or had to deal with – such as managing their own finances – and for which they lacked the necessary social and cognitive skills to be able to undertake them successfully. This shift in social and healthcare policy was said to expose some individuals to risk, not only from the demands of everyday life, but also from members of society who were willing to take advantage of their vulnerability. The Law Commission (1995) termed this “abusive normalisation”.

5 key points

1 Before the Mental Capacity Act 2005 there was a common law presumption that individuals had mental capacity to make decisions

2 The MCA provided a definitive legal framework for decision making when individuals lack capacity

3 Before the Act, capacity was sometimes judged on an individual's appearance, behaviour and on decision outcomes

4 The MCA aimed to ensure capacity was evaluated using functional and diagnostic tests

5 Effective introduction of the MCA required cultural and attitudinal change in practice



Patients can appoint someone to act in their best interests should they lack capacity

At this time there was also a review of the law governing situations where people either lacked, or had impaired, capacity to make decisions. The right to individual autonomy was recognised in law and, although there was no specific legislation or act of parliament upholding this right, several legal cases provided a framework establishing some key principles, including the need for health professionals to obtain a patient's consent before proceeding with any form of treatment or intervention.

Capacity to consent

It was recognised that patients may not always be able to understand what a particular treatment involved or evaluate its potential risks and benefits. A patient in those circumstances would not be able to provide consent, so it would be unlawful for the practitioner to proceed. As a result, before proceeding with an intervention, health professionals had to be sure their patient had the mental capacity necessary for consent to be valid; however, assessing this was often difficult (Taylor, 2014a; 2014b; 2013a; 2013b).

In the years before the MCA was introduced, the legal test for mental capacity was defined in cases such as *Re C (An Adult: Refusal of Treatment)* [1994] (*Re C*) (Box 1). This set out the test of mental capacity in common law: individuals were presumed to have the mental capacity to make decisions unless it could be shown that they were so cognitively impaired they were not able to:

- » Understand and retain information relating to the proposed treatment;
- » Believe it;
- » Evaluate it and use that evaluation to arrive at a choice.

The legal test of capacity was relatively decisive but the law was less clear about how to proceed when the patient lacked decision-making capacity. This issue was brought to the fore in the 1989 case of *F v West Berkshire Health Authority and another (Mental Health Act Commission intervening)* (*Re F*) (Box 2). Both the Court of Appeal and, subsequently, the House of Lords made detailed consideration of the legal authority for treatment when a patient lacks the mental capacity to consent, and it was acknowledged that changes in the law after the Mental Health Act 1959 was introduced had left a gap.

Although the Mental Health Act 1983 could be used when it was necessary to detain an individual to treat a specified psychiatric disorder, it could not be used as a means of justifying non-consensual

BOX 1. CASE STUDY: HAVING CAPACITY

Mr C had delusional schizophrenia and a gangrenous leg. His doctors considered amputation to be necessary to save his life but he refused this treatment, saying he would rather die with two legs than live with one. The doctors considered this decision to be irrational, and believed his mental health had impaired his decision making capacity to such an extent that his right to self-determination and the existing common law presumption of decision-making capacity should be set aside (Taylor, 2014b; Taylor, 2013a).

The doctors asked the court for an order that the treatment go ahead without Mr C's consent but the court disagreed, stating that there was clear evidence that Mr C understood and retained information relating to the proposed treatment, believed it, could evaluate it and, on this basis, had arrived at a choice.

treatment of conditions unrelated to the patient's mental health condition. This point has been subject to some confusion, as evidenced in the 1998 case of *St George's Healthcare NHS Trust v S*, in which a young woman was unlawfully detained under Section 2 of the Mental Health Act 1983 so a Caesarean section could be performed against her will.

Lawful treatment

There was no legal provision for one adult to give consent on behalf of another and, although the state had legal jurisdiction to give consent on behalf of children, it was no longer able to consent on behalf of adults who were incapacitated. This presented a legal dilemma: how could health professionals be legally obliged to fulfil their duty of care to patients but then potentially be prevented from doing so because the patient was not able to provide the consent required to make the treatment lawful? (Taylor, 2013a; 2013b).

Emergency treatment could be legally justified on the grounds of necessity so the House of Lords decided to extend the common law principle of necessity to some circumstances – such as *Miss F's* (Box 2) – so treatment could proceed lawfully as long as it was in the “best interests” of the patient. In the 1989 case of *Re F*, it was determined that the:

“...operation or treatment will be in their best interests only if it is carried out in order to either save their lives or to ensure improvement or prevent deterioration in their physical or mental health”.

This principle was subsequently termed the “general authority” (Law Commission, 1995) or the “general authority to act reasonably”. However, there were concerns this was ill defined and the extent of its application was unclear. This not only left the person lacking capacity potentially vulnerable to those making decisions on their behalf, but the proxy decision makers

also lacked the protection of a clear legal framework (House of Lords and House of Commons Joint Committee on the Draft Mental Incapacity Bill, 2003).

Legal deficiencies

The case of *Re F* [1989] came as the Law Commission was commencing its review of the law on decision making and those who are mentally incapacitated. This indicated some deficiencies so the commission led an intensive period of consultation. This resulted in some key findings, including:

- » A need to “provide a unified and comprehensive scheme within which people can make decisions on behalf of, and in the best interests of, people who lack capacity to make decisions for themselves” (Law Commission, 1995);
- » The common law presumption of capacity was not always upheld;
- » There was uncertainty over the common law test of capacity.

Rather than upholding the principles set out in the case of *Re C*, which consider the individual's functional ability to make decisions, there was evidence that capacity was being determined on the basis of decision outcomes. Although it had been established in cases such as *Re MB (Adult: Medical Treatment)* [1997] that a “... mentally competent patient has an absolute right to refuse consent to medical treatment for any reason, rational or irrational, or for no reason at all, even where that decision may lead to his or her own death,” there was evidence that assessments of capacity were being triggered by the outcome of patients' decisions (Raymont et al, 2004). This occurred in *Re MB* [1997], as well as in the *Re C* [1994] and *Re T (Adult Refusal of Treatment)* [1993] cases.

Best interests

Careful consideration was also given to the framework underpinning decisions made

on behalf of a person lacking capacity. A Green Paper on the subject gave unequivocal support for this to be determined by the principle of “best interests”, which required determination of both “past and present wishes and feelings of the person concerned and the factors the person would consider if able to do so” (Lord High Chancellor by Command of Her Majesty, 1997).

The Green Paper also recommended consulting other relevant people, such as the patient’s family, doctors and other carers, to gain further information about:

- » What the individual’s preferences would be;
- » Their view of what would be in that person’s best interests.

It was also recommended that any decision must have the least restrictive impact on the individual’s freedom (LHCCHM, 1997).

Given the lack of clarity it is perhaps not surprising that, before the MCA was enacted, some health professionals did not fully understand the law relating to consent to treatment. Indeed, 15% of doctors and final-year medical students in one study incorrectly believed they could lawfully treat a competent adult in the absence of consent (Jackson and Warner, 2002). This confusion was more pronounced if there was reason to doubt the patient’s decision-making capacity (Evans et al, 2007): evidence suggests that patients with cognitive impairment were sometimes unjustifiably excluded from the decision-making process and their right to autonomy unlawfully compromised (Taylor, 2005; 2014c). In view of such concerns, the Law Commission recommended that any new legislation should:

- » Reinforce the presumption of capacity;
- » Provide a functional test of capacity;
- » Set out a clear protocol for making

decisions in the best interests of the person lacking capacity (Law Commission, 1995).

The Mental Capacity Act 2005

Testing capacity

The Mental Capacity Act 2005 was based on five fundamental principles (Box 3). Although there must be a presumption of capacity, it also provided a test of incapacity, including:

- » Diagnostic test:

“...a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of the mind or brain”;

- » Functional test (to be applied if the diagnostic test is satisfied) – as the common law test set out in Re C [1994] but with no requirement to “believe” the information given: a person has capacity to make a decision if he is able to:
 - Understand the information relevant to the decision;
 - Retain that information;
 - Use or weigh that information as part of the process of making the decision;
 - Communicate his decision (whether by talking, using sign language or any other means).

Given the statutory presumption of capacity, patients may only be regarded as lacking capacity to make a particular decision if, after all practicable steps have been taken to support their ability to make decisions, they fulfil the requirements of the statutory diagnostic and functional tests.

Capacity must not be judged on the basis of individual’s appearance, age, behaviour or any other factor that might give rise to inferences about their decision-making capacity, which was thought to happen before the MCA was introduced

(Taylor, 2005; Raymont et al, 2004; Law Commission, 1995).

Filling the gaps

The MCA has made several provisions in response to the issues identified in the pre-legislative reviews (Law Commission, 1995; 1991), including the patient being able to:

- » Make advance refusals of care;
- » Appoint a Lasting Power of Attorney to make decisions on their behalf in the event of their losing decision making capacity at some point in the future.

Should the patient lose capacity, a deputy can be appointed by the Court of Protection to make decisions on their behalf about their financial matters, their property and their personal welfare (Taylor, 2014d).

Section 5 of the legislation also provides a statutory framework setting out how to proceed with necessary care interventions when the patient lacks capacity to consent to treatment.

The “general authority” principle was refined to make clear that, rather than giving proxy decision makers new powers, it was intended only to clarify the uncertain principle of necessity set out in Re F [1989]. The need for all formal and informal carers to understand that this provision applies only to routine daily decisions – not emergency situations where time pressures mean it is not possible to obtain permission from any third party with the authority to give it – was emphasised in the 2003 Draft Mental Incapacity Bill. Further guidance is provided in the MCA Code of Practice (Department for Constitutional Affairs, 2007).

Evaluating the MCA

The framework offered by the MCA was welcomed as a way to protect and uphold the rights of individuals who have compromised or absent decision-making capacity, be that absence a result of mental ill health, dementia or learning disabilities (Taylor, 2014a; Herissone-Kelly, 2010). Millions of pounds were made available to train health professionals in the principles of the new legislation (House of Lords Select Committee on the Mental Capacity Act [HLSCMCA], 2014; DH, 2006) but mechanisms to evaluate how far the MCA has achieved its aims are limited. Although the DCA published a regulatory impact assessment for the Mental Capacity Act in June 2004, it:

- » Made no clear provision for assessing how far the Act fulfilled the government’s objectives;

BOX 2. CASE STUDY: LACKING CAPACITY

Miss F, a young woman with considerable learning disabilities – she had the intellectual development comparable to that of a four or five-year-old child – was a long-term resident in a hospital for people with learning disabilities. She was engaging in a sexual relationship with a fellow resident and, while there was no desire to end this relationship and no question was raised about her capacity to consent to sexual intercourse, her mother and professional carers were concerned she lacked the mental capacity to cope with the possible outcomes of the relationship, including pregnancy and childbirth. As such, effective contraception was considered essential.

Given the combined effect of her physical health and cognitive state, the general view was that it would be in Miss F’s best interests if she was surgically sterilised but that she lacked the mental capacity necessary to consent to this. Given the implications of the surgery – permanent deprivation of the ability to have children – clarification was sought on the legality of performing the operation without her consent.

BOX 3. MENTAL CAPACITY ACT 2005: FUNDAMENTAL PRINCIPLES

The Mental Capacity Act 2005 was based on the following five fundamental principles:

- Decision-making capacity should be presumed
- An individual must be provided with support so that, wherever possible, they can make their own decisions
- An individual has the right to make what might appear to be unwise decisions
- Decisions made on behalf of a person lacking capacity should be in their best interests
- Any proxy act or decision should constitute the least restrictive alternative

- » Did not indicate any baseline criteria against which it would be assessed (HLSCMCA, 2014).

Instead, it provided only a broad view of how a combination of qualitative and quantitative data would enable evaluation of key aspects of the legislation, while acknowledging that this would be “quite difficult to measure” (DCA, 2004). In practice, reliance must instead be made on the HLSCMCA’s (2014) report, practice-based research reports and law reports. The findings to date will be summarised here, and considered in the second article of this series.

The HLSCMCA (2014) report presents some disappointing findings, indicating that, although the MCA has drawn attention to the rights of some of the most vulnerable members of society (with practice exemplars in some areas), implementation has yet to fulfil its primary aims; it could, at best, be described as “patchy” but sometimes is even “poor” (HLSCMCA, 2014). Particular areas of concern include:

- » The lack of definitive criteria in the legislation and the Code of Practice (DCA, 2007) to specify at which point capacity to make decisions should be challenged, thereby initiating an assessment of capacity (Taylor, 2014d);
- » Practitioners not being clear on what is meant by the “presumption of capacity”;
- » Gaps in practitioner knowledge of the 2005 MCA.

When to assess capacity

Evidence suggests that practitioners’ historic tendency to equate acquiescence with capacity (Raymont et al, 2004) persists in contemporary practice. This generally means that assessments of capacity will be triggered when patients refuse treatment – as in CC v KK and STCC [2012]. If practitioners continue to be unsure when they should assess capacity, refusals of treatment might also inappropriately remain unchallenged, resulting in patients being

deprived of treatment that may be in their best interests (Bastian et al, 2011).

Presumption of capacity

The report also suggested practitioners may not be clear on what is meant by the term “presumption of capacity” and may make inappropriate judgments based on an individual’s condition or behaviour (HLSCMCA, 2014).

Knowledge gaps

Research findings also indicate that, despite training, gaps in practitioner knowledge of the MCA persist (Willner et al, 2011). Studies have shown that, even when clinicians have a knowledge and/or understanding of the provisions of the MCA, this is not always applied to their practice (Emmet et al, 2013; Wilson et al, 2010).

Conclusion

The MCA was introduced to resolve the legal difficulties once encountered when caring for patients with impaired or absent decision-making capacity, while promoting and – as far as possible – upholding their right to autonomy. Although it does provide a framework for decision making when capacity is absent, evidence suggests it has yet to fulfil its aims. The second article in this series will consider possible reasons for this and offer recommendations for practice and education. **NT**

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