



## special articles

*Psychiatric Bulletin* (2005), 29, 423–427

**ROWENA JONES**

### Review of the Mental Capacity Act 2005

An incapacity to make decisions can crucially affect quality of life. Those who lack capacity are vulnerable to abuse from others, ranging from overpaternalism to exploitation, neglect and violence. Historically, those lacking capacity have not been served well by statutory services, with institutionalisation being commonplace. Community care has had its successes and failures; although care provided is often well intentioned and of good quality, abuses of power and trust continue to occur.

Legislation to protect those with incapacity has built up in a piecemeal fashion. Financial matters are currently managed by appointees under social security regulations, donees of enduring power of attorneys (EPAs) or Court of Protection appointed receivers. There is concern that abuse, particularly of the EPA system, is widespread. Healthcare and welfare decisions are not covered by statute law, although gaps are partially filled with case law examples. Those making such decisions on behalf of the incapacitated rely on a common law defence of necessity to justify their actions.

Professional bodies and voluntary organisations dealing with mental disability have lobbied the government for years to produce clear legislation and the Mental Capacity Bill followed 16 years of consultation. It has recently received Royal assent and is now known as the Mental Capacity Act 2005. It is not clear as yet when the Act will come into force and further legislative procedure is still required. The Act has been broadly welcomed although there are still some concerns from user organisations that it may not have gone far enough in terms of empowerment with decision-making, and protection from abuse.

#### Aims of the legislation

The overall aim of the Act is to balance protection of those lacking capacity against protection of those providing care. It introduces a framework whereby laypersons and professionals can legally make decisions on a person's behalf, subject to a statutory requirement to act in the person's best interests and being held accountable for their actions.

The Act emphasises the importance of a functional approach to capacity. Capacity is therefore not seen as a

unitary phenomenon, deemed present or absent, but rather is decision-specific. People should be presumed to have capacity unless proven otherwise. There is a principle of enablement of capacity, i.e. all practicable steps should be taken to enable people to make decisions for themselves, before resorting to decision-making on their behalf. The Act aims to promote autonomy in decision-making. Those who anticipate the onset of incapacity may nominate people whom they would like to act for them when the need arises. It also includes advance directives, whereby a capable person can state which treatments they wish to refuse should they become incapacitated in the future.

There is a chapter setting out the law in relation to research involving people with incapacity, to ensure that such research is appropriate and subject to ethical review.

Finally, the Act will bring all jurisdictions relating to capacity matters under one roof, namely the new Court of Protection, headed by the Public Guardian. It is thus hoped that procedures will be streamlined and the court will be able to build up a body of expertise to promote best practice.

#### Assessment of capacity

The Act states that 'a person lacks capacity... 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'. It is therefore clear that capacity is decision-specific and also that assessment is a two-stage process: first, as to whether a disorder of mind or brain is present, and second, whether this impairs capacity. It is important that this is emphasised, as it protects the rights of individuals without a disorder of mind or brain who choose to make unwise or risky decisions.

The Act applies to carers as well as professionals. Professionals will obviously be involved in decisions such as consent to medical treatment or capacity to make a will. Carers will be expected to be able to judge a person's capacity for more everyday decisions and will be justified in acting on their behalf, providing they have a 'reasonable belief' that the person lacks capacity. Although professionals already receive guidance on assessment of capacity (British Medical Association & The Law Society,



2004), the government acknowledges the need to provide clear guidance for laypersons. A draft code of practice (Department of Constitutional Affairs, 2004) has been drawn up which provides information in an appropriate form for the general public.

The Act states clearly that 'all practicable steps' must be taken to optimise a person's capacity (e.g. by providing information in appropriate format or by communication aids), before an assumption can be made of incapacity.

The Act does not distinguish between permanent and temporary loss of capacity. However, decisions taken on behalf of someone thought to temporarily lack capacity should take account of the likelihood of capacity returning.

## Making decisions

### Who can make decisions?

Any person involved in the care of a person who lacks capacity will be required at times to make decisions on that person's behalf. Informal carers make decisions for people in terms of helping them in their day-to-day lives, for example, providing assistance with personal care, buying shopping with the person's money and deciding how they might spend their day. Professionals become involved in health or major welfare decisions. Doctors are required to make decisions about medical treatment when a person is unable to provide consent. Health and social care professionals are involved in making decisions about where a person with incapacity should live. Powers in the Act will enable people who anticipate incapacity to grant specific individuals the powers to make financial and personal welfare decisions on their behalf for when they lose capacity in the future. These powers are called lasting power of attorneys and are covered in more detail below. Finally, the new Court of Protection will be able to make complex or controversial decisions regarding the care of people with incapacity, and if necessary can appoint a deputy to provide ongoing decision-making for the person involved. The principles for all these layers of decision-making are the same and they are clearly set out in the Act. The decision-maker must believe the person lacks capacity to make the decision in question and must take account of all available information to ensure that they act in the person's best interests. They must encourage the person's participation in the decision-making and always consider what is the least restrictive option. The Act sets out a best-interests checklist of the minimum information that must be considered, and this is explained further in the codes of practice. It is also made clear that decision-makers, both formal and informal, have a responsibility to follow the codes, and failure to do so can be used as evidence against them in court proceedings.

During scrutiny of the Act various parties expressed concern about the potential for abuse of powers by carers. The Law Society commented to the Scrutiny Committee that powers of the Act provided a 'blank cheque' to carers (Joint Committee on the Draft Mental

Incapacity Bill, 2003). Although such concerns are real, it is also clear that decisions are currently being taken on a day-to-day basis without a clear legal framework and with the new Act no new powers are actually being given to carers; rather the law is intending to legalise and thus protect current good practice. In order to balance the protection of incapacitated people with the defence of those caring for them the Act has introduced a new criminal offence of 'ill treatment or wilful neglect' which will cover the area of carers taking advantage of or abusing their position. It remains to be seen whether these powers will be sufficient to counteract abuse.

### Lasting power of attorney

The Act will widen the current scope of the enduring power of attorney (EPA) system to enable people with capacity to appoint donees to make welfare decisions as well as financial ones on their behalf, should they lose capacity in the future. These will be referred to as lasting power of attorneys (LPAs). Evidence, however, has been presented to the Scrutiny Committee by the Master of the Court of Protection that abuse of EPAs currently occurs in 10–15% of cases (Joint Committee on the Draft Mental Incapacity Bill, 2003) and there is the additional scope for conflict of interest with an LPA if an attorney is making both healthcare and financial decisions. It is therefore recommended that a person be encouraged to consider appointing different attorneys for different types of decision.

One recognised period where abuse of EPAs has occurred is in the time before they are registered. When an EPA is made both the donor and donee can make financial transactions until the donor loses capacity. At that point, the EPA is registered and the donor is no longer able to make decisions. Currently, it appears that EPAs are not always being registered and donees are continuing to use them unchecked. The Act therefore states that LPAs will be registered when they are first made and thus will be open to scrutiny from the outset. Lasting power of attorneys will broadly be divided into financial LPAs and welfare LPAs. Each LPA will set out clearly which decisions are to be included and excluded, and will only have the power to refuse life-sustaining treatment if specifically included. Like EPAs, financial LPAs will become operational at the outset, unless stated otherwise, and will be used jointly by donor and donee until the donor loses capacity. Welfare LPAs will only become active when the donor loses capacity for the decision in question.

Although the Act stresses that LPAs can only make decisions which the donors are incapable of making themselves, there is clear potential for their misuse in terms of being inaccurately perceived as an 'all or nothing' phenomenon. Loss of capacity in one area could lead to the view that an LPA was now 'active', giving the donee wide-ranging powers over finance, health or welfare. The codes of practice will need to emphasise the need to reconsider a person's capacity for each decision being made. The draft codes provide a list of duties for the



holders of LPAs and these include duties of care, confidentiality and the need to keep written records of their actions.

## Advance directives

These have been included in the Act, despite some controversy, and allow a person to specify treatments that they would wish to refuse should they become incapacitated in the future. The main concern about advance directives is that they may encourage 'euthanasia by the back door' (Joint Committee on the Draft Mental Incapacity Bill, 2003). However, case law has already found repeatedly in favour of advance directives and their omission from new legislation would leave a confusing gap. Also, it should be recognised that advance directives follow the principle of increasing autonomy in decision-making which is felt to be a defining feature of the Act.

The draft codes of practice sets out procedures by which advance directives should be used. Professionals will be expected to seek out advance directives if they have reason to believe they exist. They will need to be able to assess the validity of the advance directive for the particular circumstance. A valid advance directive is equivalent to a person's contemporaneous consent. If there is doubt or controversy, the Court of Protection can issue a judgment on the validity of an advance directive. As it stands, advance directives do not need to be in writing; however, it is clear that the advice to those making such directives is to provide as much documentation as possible. The draft codes do indicate that advance directives that specifically involve the refusal of life-sustaining treatment need to be in writing and witnessed.

Only advance refusals, i.e. treatments that a person would wish to refuse, are legally binding in the current Act. Other advance statements detailing preferences about treatments are recognised as important and are relevant in consideration of best interests. User groups, such as Rethink (<http://www.rethink.org>), have stressed the value of such advance statements and it would certainly seem good practice to promote their development, particularly for those suffering from serious mental illnesses which lead to fluctuating incapacity.

## Court of Protection and Court-appointed deputies

If a person lacks capacity and has not appointed an LPA the Court of Protection may be involved in the handling of finances or complicated health or welfare decisions. The Court may make a declaration as to whether a person has capacity for a decision or not. It may provide a judgment as to the validity of an advanced directive or LPA. The Court may also make specific decisions in complex, controversial or particularly grave cases and, if there is a need for ongoing decision-making, will have the power to appoint a deputy to do so. Court-appointed deputies will be able to make financial and/or welfare decisions, though these powers will be as 'limited in

scope and duration as is reasonably practicable' (Mental Capacity Act 2005).

As with the LPA system, the appointment of deputies able to make financial and welfare decisions for a person lacking capacity could lead to conflicts of interest. Scenarios may arise, such as a social worker being appointed as a deputy for several care home residents. There will need to be clear guidance in the codes of practice as to how deputies are chosen, and their powers monitored and appropriately restricted. According to the draft codes, deputies will not be able to make decisions regarding refusal of life-sustaining treatment, though this is not made clear in the Act.

## How will decisions be made in practice?

When a person makes a decision on behalf of someone with incapacity this will be covered by different sections of the new legislation. If the decision-maker is the donee of an LPA and the scope of the LPA covers the decision in question then they will be making decisions under this power. This is covered in Section 9 of the Act. Similarly, the Court of Protection may make a decision or appoint a deputy to make ongoing decisions under Section 16 of the Act.

Other decisions will be covered by Section 5 of the Act. These Section 5 Acts will be wide-ranging, from everyday decisions made by carers to major health and welfare decisions. As yet there is no guidance on the paperwork or common parlance involved. Presumably there will be forms akin to Mental Health Act 1983 section papers for medical procedures or committal to hospitals or residential facilities. It seems unlikely that carers making everyday decisions would complete such formal paperwork; however, it is clear that they will be encouraged to provide written records of their actions, in particular when financial transactions are involved.

## Role of advocacy services

Earlier versions of the Capacity Bill made little reference to independent advocacy but it was clear from the responses to the Bill by both user and professional organisations that this was unsatisfactory. The Making Decisions Alliance, which represents key voluntary organisations including Mencap, Age Concern and the Alzheimer's Society, stated that 'independent advocates are uniquely placed to ensure that the fundamental principles of the legislation, such as the paramount importance of the individual's wishes and feelings, are translated into the practice of substitute decision-making' (Making Decisions Alliance, 2004).

People with incapacity who lack supportive family or friends are among the most vulnerable in society. An obvious example would be an elderly care home resident without relatives available to make care staff aware of their particular circumstances and preferences. As the Scrutiny Committee criticising the Bill stated, 'small decisions often have a disproportionate effect on the morale and quality of life of those who are disadvantaged or



vulnerable' (Joint Committee on the Draft Mental Incapacity Bill, 2003). In such situations, or where there is family dispute, independent advocates can champion the needs and wants of the individual.

The government itself had already stated the importance of advocacy in the White Paper *Valuing People*, setting out standards for care of people with learning disabilities. This document states that 'effective advocacy services can transform the lives of people with learning disabilities by enabling them to express their wishes and aspirations and make real choices' (Department of Health, 2001).

The Act has now responded to these criticisms and includes a chapter on advocacy. It sets out situations where advocates must be made available for people with incapacity. If a person requires serious medical treatment or provision of accommodation in either a National Health Service hospital or care home, and there is no key person available to be consulted as to their wishes, then an independent advocate must be appointed to consider and represent their best interests. There will be clear resource implications for the provision and training of sufficient advocacy services.

### Overlap with Mental Health Act legislation and the 'Bournewood gap'

The Scrutiny Committee recommended that incapacity legislation be introduced prior to new mental health legislation so that the latter can be better tailored to work in tandem with the former. Obviously, the two areas overlap, and the Richardson Report (Department of Health, 1999) suggested early into consideration of new Mental Health Act legislation that a capacity test could form the basis of whether treatment could be enforced for mental disorder, with the caveat that additional powers may be necessary to treat those who pose a serious risk to themselves or others, which would override a capacity test. However, the Draft Mental Health Bill does not appear to be progressing in that direction and has not included a capacity test for detention. On a different tack, the remit of mental health law can be considered as different from that of incapacity. Incapacity legislation is intended to provide decision-making for those unable to do so, including medical treatment. On the other hand, mental health law imposes treatment on those who are actively refusing. There is overlap when a person lacking capacity is actively refusing treatment for a mental disorder. This has been a longstanding grey area recognised since the Bournewood case, in which a man with autism was detained in hospital for treatment without recourse to the Mental Health Act 1983 as it was judged that he lacked capacity (*L. v. Bournewood Community and Mental Health NHS Trust*, 1998). This high-profile case has recently been taken to the European Court of Human Rights and a judgment was released in October 2004 (*HL v. UK*, 2004). The European Court of Human Rights has ruled that in the Bournewood case, the patient was deprived of his liberty as there were insufficient procedural safeguards in place regarding his admission and continued detention. It is unclear at present as

to how much the government is planning to amend the Capacity Act to take account of this ruling. A Department of Health consultation process (Bournewood Consultation, Department of Health, 2005) has recently been completed but has not published its response. The current state of play in the Act is that incapacitated patients actively refusing treatment for mental disorder will come under the jurisdiction of the Mental Health Act 1983, which will 'trump' the Capacity Act. There is, however, concern about the discrimination inherent in such an approach, whereby assenting incapacitated patients are denied the safeguards of mental health legislation with the built-in mechanisms for appeal and second opinion. There is a clear population of people with incapacity detained in hospitals or care homes whose freedom can be considered restricted. Unless some similar provision for regular review of their circumstances is built into the Capacity Act then it runs the risk of incompatibility with the Human Rights Act 1998.

### How will the Capacity Act affect psychiatric practice?

Although the detail is still awaited in terms of practical administration of the various sections, the new Act provides a clear set of procedures for all doctors, including psychiatrists, to follow when they are involved in the treatment of patients with incapacity. Doctors will be able to make medical decisions for their patients using the Capacity Act rather than relying on the common law principle and case law examples. The Capacity Act is clear that the decision-maker, be it a doctor, other professional or layperson, is responsible for making an assessment of capacity. Psychiatrists frequently receive requests from other doctors, social workers and lawyers to provide their opinion on whether capacity is present or absent in a particular situation. Although we do have expertise in the management of patients with incapacity it is inappropriate and unfeasible for psychiatrists to be routinely called upon in such circumstances. However, unless the training of other professionals in assessment of capacity is improved, it is possible that the introduction of the Capacity Act and the shift in attention on to capacity assessment will be accompanied by a deluge of requests for psychiatric assessment. It is hoped that the heightened awareness of the issue of capacity brought about by legislation will improve standards in capacity assessment across the board.

Psychiatrists also need to consider the implications of the European Court of Human Rights ruling on the Bournewood case and be alert to the likelihood of further changes to the Capacity Act in response.

### Conclusions

Many of the criticisms levelled by professional and user organisations have been addressed in the revised Act. It provides a valuable platform for people with disorders affecting capacity, either enabling them to make decisions themselves or to have sound decisions made on

special  
articles

their behalf. Introduction of legislation in itself should help with the wider issue of promoting attitudes that recognise the rights of those with incapacity.

The main outstanding concerns appear to be as to whether there are sufficient safeguards written into the Act to recognise and tackle abuse. Tied in with this is the question of resources, as the safeguards rely on the provision of adequate legal aid, access to the Court of Protection, inspection and investigation of those providing informal and formal care and the training and resourcing of advocacy services.

Although the Act should not be unduly delayed, it would be disappointing if the management of 'Bournewood gap', i.e. compliant incapacitated patients in the light of the European Court of Human Rights decision, was not clearly addressed before the law comes into force.

Finally, the medical profession as a whole needs to recognise and fulfil its responsibility in training doctors to assess capacity. As Eastman & Peay (1998) noted in a *British Medical Journal* editorial, capacity is finally set to become a 'major clinicolegal issue in this country'.

## Declaration of interest

None.

## References

- BRITISH MEDICAL ASSOCIATION & THE LAW SOCIETY (2004) *Assessment of Mental Capacity. Guidance for Doctors and Lawyers* (2nd edn). London: BMJ Books.
- DEPARTMENT OF CONSTITUTIONAL AFFAIRS (2004) *Mental Capacity Bill: Draft Code of Practice*. London: Department of Constitutional Affairs (<http://www.dca.gov.uk/menincap/mcdraftcode.pdf>).
- DEPARTMENT OF HEALTH (1999) Report of the Expert Committee. Review of the Mental Health Act 1983. London: Department of Health.
- DEPARTMENT OF HEALTH (2001) *Valuing People. A New Strategy for Learning Disability for the 21st Century*. London: TSO (<http://www.archive.official-documents.co.uk/document/cm50/5086/5086.pdf>).
- DEPARTMENT OF HEALTH (2005) *Bournewood Consultation. The*
- Approach to be Taken in Response to the Judgement of the European Court of Human Rights in the "Bournewood" Case*. London: Department of Health (<http://www.dh.gov.uk/assetRoot/04/10/86/41/04108641.pdf>).
- EASTMAN, N. & PEAY, J. (1998) Bournewood: an indefensible gap in mental health law. *BMJ*, **317**, 94–95.
- JOINT COMMITTEE ON THE DRAFT MENTAL INCAPACITY BILL (2003) *First Report*. London: United Kingdom Parliament (<http://www.publications.parliament.uk/pa/jt200203/jtselect/jtdmi/189/18902.htm>).
- MAKING DECISIONS ALLIANCE (2004) *Briefing for Chief Executives on the Mental Incapacity Bill and the Work of the Making Decisions Alliance (MDA)* ([http://www.makingdecisions.org.uk/chief\\_executive\\_briefing\\_feb04.pdf](http://www.makingdecisions.org.uk/chief_executive_briefing_feb04.pdf)).
- HL v. UK, European Court of Human Rights*, C [2004] J 4269.
- L v. Bournewood Community and Mental Health NHS Trust* [1998] 2 WLR 764.
- Rowena Jones** Specialist Registrar, Services for Older People, Queen Elizabeth Psychiatric Hospital, Edgbaston, Birmingham B15 2QZ, e-mail: [rmj@doctors.org.uk](mailto:rmj@doctors.org.uk)