

Assessing mental capacity: the Mental Capacity Act

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BMJ 2008;336:322-5
doi:10.1136/bmj.39457.485347.80

Assessing mental capacity is an important part of a clinician's role, and the recent Mental Capacity Act can help doctors when making such decisions

Clinicians are often confronted with decisions about mental capacity. Healthcare workers in England and Wales should therefore be aware of the recent changes to how capacity is assessed and the way that adults lacking capacity are dealt with since the implementation in 2007 of the Mental Capacity Act 2005.¹

What does the Mental Capacity Act do?

The act protects people who lack the mental capacity to make decisions. Until the Mental Capacity Act 2005 was implemented no statutory law covered this area. Courts previously dealt with capacity under "common law," which consists of the accumulated judgments of individual cases. The Mental Capacity Act is underpinned by five key principles (box 1), which are illustrated in a hypothetical scenario (box 2).

Why do I need to know about the Mental Capacity Act?

An assessment that a person lacks capacity has major implications; it gives clinicians influence over that person, and this influence could, potentially, be abused. The Mental Capacity Act provides important safeguards to patients' rights, and it also provides help for clinicians in dealing with capacity problems. In general hospitals, more than 30% of patients on acute medical wards may lack capacity.² A slightly higher proportion (44%) of psychiatric inpatients lack capacity to make the primary decision for which they were admitted.^{3,4} Two million people in the UK are estimated to lack capacity through mental illness, learning difficulties, dementia, or physical illnesses that affect brain function (such as delirium or head injury).⁵

Until now, capacity has mostly been assessed in patients who refuse the management suggested by the clinical team; such patients are often referred to psychiatrists for capacity assessments.⁶ Clinicians are also often unaware that their patients may have difficulty in making decisions.² Surveys indicate that

clinicians have limited understanding of the law pertaining to capacity.^{7,8}

What has the Mental Capacity Act changed?

Much of the Mental Capacity Act simply codifies previous common law, but it also changes the law in significant ways. The act introduces several new concepts and services: a code of practice; a criminal offence for wilful neglect or ill treatment of people without capacity; an independent mental capacity advocate service; and advance decisions. It has also expanded the role of several existing services, such as the court of protection and frameworks such as lasting power of attorney and court deputies.

What is the code of practice?

The code accompanies the Mental Capacity Act, and it is designed to guide those responsible for interpreting the act.⁹ Clinicians are legally required to "have regard to" (have read and understood) its guidance and, if later asked, prove they did. Consequently, any departures from this will be hard to justify. The code of practice can be viewed and downloaded online.⁹

What is the independent mental capacity advocates service?

The service comprises the independent organisations that assign someone to support and represent "unbefriended" people who lack capacity. Their recommendations do not need to be adhered to by clinicians, although they should be taken into account as part of the decision making process. Each local authority (borough) has appointed its own independent mental capacity advocates service.

The code specifies when to instruct an independent mental capacity advocate. They can be instructed for care reviews or adult protection cases, but they must be instructed and then consulted when serious medical treatment is being proposed (such as ventilation, major surgery, chemotherapy, and discontinuation of artificial nutrition or hydration). They must also be involved when accommodation for more than 28 days in hospital or eight weeks in a care home is being arranged or changed.

Box 1: Five key principles of the Mental Capacity Act

- Principle 1: Capacity should always be assumed. A patient's diagnosis, behaviour, or appearance should not lead you to presume capacity is absent
- Principle 2: A person's ability to make decisions must be optimised before concluding that capacity is absent. All practicable steps must be taken, such as giving sufficient time for assessments; repeating assessments if capacity is fluctuating; and, if relevant, using interpreters, sign language, or pictures
- Principle 3: Patients are entitled to make unwise decisions. It is not the decision but the process by which it is reached that determines if capacity is absent
- Principle 4: Decisions (and actions) made for people lacking capacity must be in their best interests
- Principle 5: Such decisions must also be the least restrictive option(s) for their basic rights and freedoms

What is a lasting power of attorney?

This replaces the enduring power of attorney system, where a person could appoint a named person (the "donee") with the authority to make decisions on their behalf if they lost capacity. Previously this only applied to property and affairs. The Mental Capacity Act widens this authority to decisions about personal welfare, including health care and social affairs. It includes all decisions except those about the withdrawal of life saving treatment, unless explicitly authorised in the agreement. Existing enduring power of attorney agreements will continue as before, but new appointments will be to the lasting power of attorney system.

Property and affairs lasting power of attorney agreements can start before a person has lost capacity, but personal welfare ones cannot. Clinicians treating people without capacity must follow the decision of a donee, unless they are thought not to be acting in the person's best interests or to be abusing the person lacking capacity, in which case you should follow the guidance of the code of practice. In serious cases you may need to seek a decision from the court of protection.

When making a lasting power of attorney agreement, the limits of the powers granted are specified—this is known as the "nature and effect." Decisions about life sustaining treatment must be specified in the lasting power of attorney, and a signed statement from the attorney and a certificate completed by an independent third party are required.

A parallel system exists where the court of protection can appoint a deputy for someone who already lacks capacity. The deputy is likely to be a family member or director of social services. The deputy can consent on the person's behalf but can never consent to decisions that will shorten the person's life.

What are advance decisions?

Advance decisions can be drawn up by anybody to specify treatments they would not want if they lost capacity. They cannot demand treatments. Provided

advance decisions are made when the person had capacity, and they are sufficiently specific to cover the patient's current predicament, clinicians must respect them. They can be made verbally and can be reversed by the individual if they regain capacity. Advance decisions that refuse life sustaining treatments (such as ventilation) have to be written, signed, and witnessed to be valid. It is incumbent on clinicians to find out if an advance decision exists and assess whether it is valid.

What is the court of protection?

This specialist court has been greatly changed by the Mental Capacity Act. It previously only adjudicated on

Box 2: Hypothetical scenario

A 64 year old Asian man who speaks poor English presents to hospital with chest pain. Investigations reveal an ST elevation myocardial infarction and the clinical team decides to admit him. However, he is not willing to stay as he is flying to India the next day for his son's wedding. He is clearly distressed and very anxious.

In managing this case it is important to remember the principles of the Mental Capacity Act (box 1).

- Do not presume lack of capacity (principle 1) because of his anxiety or because he disagrees with the team's decision
- His capacity to make this decision should be assessed by the clinical team. To do this, his decision making ability should be optimised (principle 2) by explaining the benefits and risks of admission compared with other management options. An interpreter should be used if necessary
- If a lack of capacity cannot be proved, his decision to refuse admission must be respected, even if it is "unwise" (principle 3) or risky, because it is the decision process that is important, not the decision itself. The patient should be told how best to re-access treatment if he changes his mind or the clinical situation changes. Given the high risks associated with this decision, if the initial assessment of capacity is not clear, an expert (for example, psychiatry) opinion should be sought. The combination of angina, the realisation that he may have a serious illness, or the stress of his son's impending wedding may cause severe anxiety, although it would be rare for this to impair capacity
- If he is found to lack capacity, it must be established what is in his best interests (principle 4); this may not be what the clinical team initially thought. It may be clear, after researching his known beliefs and values, that he would have refused admission even if he still had capacity. The clinical team would be legally protected under the Mental Capacity Act if they thought it was in his best interests not to admit him
- Many options are available when acting in his best interests. These range from surgery to angioplasty to optimal drug therapy as an inpatient or outpatient. The least restrictive option must be used (principle 5) after weighing the risks, benefits, degrees of restriction, and practical consequences of each, given his clinical situation

the financial matters of people without capacity, but its role has widened to include health and welfare decisions. It will be more accessible and available to arbitrate on disputes and is now able to “establish precedent” with the same powers as the High Court.

What legal protection do I have under the Mental Capacity Act?

Section 5 of the act protects from legal liability those providing health care (and personal care) for people without capacity, provided they had “reasonable belief” that the person lacked capacity and their actions were in the person’s best interests. Documentation is key in such situations. However, the act does not protect from liability those professionals who have been negligent, or who have gone against the wishes of an attorney (or deputy) acting within the scope of their power.

How is capacity assessed?

Assessing capacity is a two stage process. For a person to lack capacity, he or she must have an impairment of

Box 3: Use of restraint under the Mental Capacity Act

- Restraint is the use (or threat) of force to make someone do something that they are resisting
- Restraint is also the restriction of a person’s freedom of movement, whether they are resisting or not
- Restraint must reasonably be believed to be necessary to prevent harm to the person lacking capacity
- Restraint must be proportional to the likelihood and seriousness of harm

or disturbance in the functioning of the brain or mind, and this defect must result in the inability to understand, retain, use, or weigh information relevant to a decision or to communicate a choice (figure). Note that there is both a diagnostic threshold and a component that is specific to a decision. Capacity can be assessed only in relation to a specific decision. This has been described as a “functional” approach rather than a “status” approach, where a person—having reached a diagnostic threshold—would be described as lacking capacity for all decisions. Capacity needs to be reassessed for each decision, particularly if the impairments fluctuate over time, as in delirium.

Under principle 3 of the Mental Capacity Act, a patient cannot be deemed to lack capacity just because the treating clinicians disagree with his or her decision. People are entitled to make unwise decisions (principle 2)—what matters is not the decision itself, but the way it was reached.

How do I decide what is in someone’s best interests?

When deciding on best interests, you should consider not just the intervention likely to lead to the best clinical outcome, but you should place yourself in the patient’s shoes and ask what they would have wanted if they still had capacity. The views of relatives and others who know the person well may be crucial to making this decision. Clinical problems have a variety of management options, ranging from doing nothing to radical treatments, and the least restrictive option should be used (principle 5 of the Mental Capacity Act).

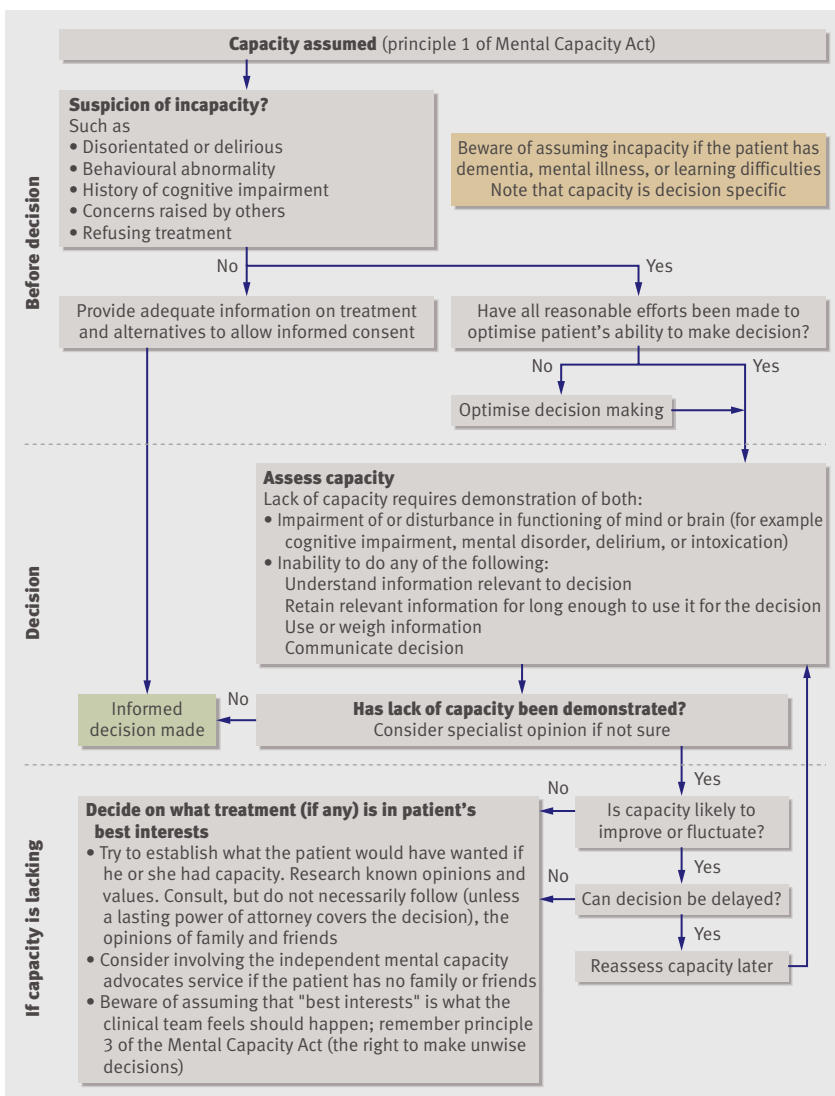
Restraint can be used to achieve this, but its use is limited by the act (box 3) and it cannot amount to “deprivation of liberty” (see interaction with Mental Health Act).

How do the Mental Capacity Act and Mental Health Act interact?

This is a complex area. The Mental Health Act is relevant only when treating a mental disorder; in most circumstances it is not relevant when treating physical illnesses.

Patients detained under the Mental Health Act who refuse physical health treatments need to have their capacity assessed. Incapacity should not be assumed in such patients (principle 1 of Mental Capacity Act).

Except when a court of protection order—a consequence of which is the deprivation of liberty—is in



Flow chart of how to decide whether or not a person aged 16 or over has capacity

Additional educational resources**General resources**

- BMJ online learning (www.bmj.com/learningmodules/capacity)—Includes multiple choice questions for self testing
- Department of Constitutional Affairs (www.dca.gov.uk/menincap/legis.htm#lpa)—Download the Mental Capacity Act and its code of practice
- Public Guardianship Office (www.guardianship.gov.uk)—Administrative arm of the Court of Protection, which provides financial protection for those without capacity and information on lasting power of attorneys
- Mental Health Act 2007 (www.opsi.gov.uk/acts/acts2007/ukpga_20070012_en.pdf)—download the new act. Its code of practice will also be available to download soon
- Making Decisions Alliance (www.makingdecisions.org.uk)—Resource for patients and relatives who want to learn more about capacity
- Royal College of Psychiatrists (www.rcpsych.ac.uk/pdf/Bournemouthfinalinterim.pdf)—Provides guidance on “Bournemouth” patients until the new Mental Health Act is implemented

In your trust or area

- Senior colleagues
- Psychiatry on call services (ideally “liaison” psychiatry if available)
- Hospital lawyers
- Clinical ethics committees
- Social services
- Court of protection
- Your personal medical defence society

place, the Mental Capacity Act cannot be used to give care involving deprivation of liberty (see code of practice for details). Treatments that are prohibited in advance decisions or treatments that are not consented to by an attorney can still be given under the Mental Health Act if they are to treat a mental disorder.

The current Mental Health Act (1983) is due to be replaced by a new one (2007) in 2008. Among other

SUMMARY POINTS

The Mental Capacity Act has resulted in increased formalisation of capacity law and assessment

The act has increased the expectation that healthcare workers should be competent at assessing capacity

The act has also increased the need for training and education, especially awareness and understanding of the code of practice, independent mental capacity advocates, and advance decisions

changes, it will modify the Mental Capacity Act by clarifying how to deal with patients who lack capacity to decide whether or not to stay in hospital (or a care home), but who do not object to staying. Such patients are referred to as “Bournemouth” patients, and the lack of statutory provisions for them is called the Bournemouth gap.

Contributors: The authors planned the article together after discussions about patients seen in clinical practice. TRJN and WC wrote the first draft, which was revised by all three authors. MH edited the final manuscript and is guarantor.

Competing interests: None declared.

Provenance and peer review: Not commissioned; externally peer reviewed.

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“BITS?”

With thumping heart but great enthusiasm, I started my clinical examination for membership of the Royal College of Surgeons, and was asked to examine a man with unilateral varicose veins. This I did briskly and precisely, and then decided to use the remaining time and be smart, so I informed the examiner that I would check for a varicocele as well.

I turned to the patient again, but suddenly found myself lost for words. I thought: “Should I say ‘scrotum’? No, it’s medical jargon. OK then, what about ‘testes’? No, it doesn’t convey an accurate picture. Perhaps ‘groin,’ but I’ve already examined that area.”

So, after a brief pause, I said, “Can I examine your bits, sir?” and, after the patient’s approval, completed the rest of the physical examination.

The moment of truth came when the results were handed over to us. I was successful, but there was a feedback note: “BITS?” At that moment the examiner appeared and gave me a quick lecture on professionalism.

This incident serves to remind me, whenever I go to see a patient, that I need to revise in my mind what appropriate words and phrases I should use.

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