Mental Capacity Act 2005: statutory principles and key concepts

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The Mental Capacity Act 2005, which came fully into force on 1st October 2007, is an important piece of legislation covering England and Wales that establishes a statutory framework for making decisions on behalf of incapacitated people. The Act puts the person who lacks decision making capacity at the centre of a more holistic decision making process and allows those who have capacity to plan ahead for when they might be unable to make decisions for themselves.

The Mental Capacity Act 2005’s main focus is on decisions concerning the care and treatment of people who lack decision making capacity and it impacts significantly on district nurses practice. District nurses must abide by the provisions of the Act and its code of practice to avoid liability for trespass to the person when caring for an incapacitated person (Mental Capacity Act 2005, section 5).

Criminal offence
As well as promoting the interests of incapable people when making care and treatment decisions the Act also introduces a new criminal offence to protect vulnerable people from willful neglect or ill treatment (Mental Capacity Act 2005, section 44).

In the first conviction for the offence, a care home manager was successfully prosecuted after he left three learning disabled residents locked in his car for three hours while he went to visit a betting shop (Denby 2008).

Code of practice
The code of practice provides guidance on the implementation of the Mental Capacity Act 2005. All those working with or caring for people who lack capacity including relatives, professionals such as district nurses and carers must have regard for the code of practice. The code describes their responsibilities when acting or making decisions with, or on behalf of, individuals who lack capacity. Although NHS trusts have gone to considerable lengths to provide their own guidance and policy on the use of the Mental Capacity Act 2005, district nurses must still have regard to the Act’s code of practice. The Act imposes a legal obligation on those acting in a professional role to have regard to the code of practice (Mental Capacity Act 2005, section 42).

ABSTRACT
The Mental Capacity Act 2005 represents the most significant development in the law relating to people who lack decision making capacity since the Mental Health Act 1959 removed the states parens patriae jurisdiction preventing relatives, courts and government bodies consenting on behalf of incapable adults (F vs West Berkshire HA (1990)).

The Mental Capacity Act 2005 impacts on the care and treatment provided by district nurses and it is essential that you have a sound working knowledge of its provisions and code of practice. In the first article of a series focusing on how the Mental Capacity Act 2005 applies to district nurse practice, Richard Griffith and Cassam Tengnah consider the principles and key concepts underpinning the Act.

KEY WORDS
Mental Capacity Act • Statutory principles • Code of practice
Who is affected by the Act

With some exceptions, the Act affects anyone aged 16 years and over. This includes adults who might lack decision making capacity such as those with dementia, learning disability, brain injury and severe mental illness. People with a temporary loss of capacity are also affected and could include people who are unconscious, drunk, under the effect of drugs or people with severe trauma and in severe pain.

Children under sixteen who lack capacity to make decisions do not generally come under the provisions of the Mental Capacity Act 2005. A person with parental responsibility can make decisions, such as treatment decisions, on their child’s behalf. (Children Act 1989, section 2 and Re W’ (A Minor) (Medical Treatment: Court’s Jurisdiction) [1993]).

However, the new Court of Protection has powers to make decisions about the property and affairs of a person under 16 years who lacks capacity and is likely to lack capacity when they are 18 years old (Mental Capacity Act 2005, section 18(3)).

For those aged between 16 and 17, the 2005 Act can be used to appoint someone as a deputy to make financial or welfare decisions. For example, the Court of Protection can decide what is in the best interest of the young person where there is disagreement about treatment.

Excluded decisions

The Mental Capacity Act’s primary concern is decision making for those who lack capacity in relation to their care and treatment. The 2005 Act will also be used to assess decision making capacity in relation to other matters such as making a will. There are however some decisions that cannot be made on behalf of an incapable person because they are either so personal to the individual concerned or governed by other legislation.

The 2005 Act sets out specific decisions which can never be made or actions which can never be carried out under the Act by family members, carers, professionals, attorneys or the Court of Protection.

Nothing in the Act permits a decision to be made on someone else’s behalf regarding consent:

- To marriage or a civil partnership
- To have sexual relations
- To a decree of divorce on the basis of two years’ separation or the dissolution of a civil partnership
- To a child being placed for adoption or the making of an adoption order
- To exercise parental responsibility for a child in matters not relating to the child’s property, or
Mental capacity

Mental capacity is the ability to make a decision. It has been described by judges as the key to a person’s autonomy (Re T (Adult: Refusal of Treatment) [1992]). If a person has capacity, district nurses are bound by their decision if not then the Mental Capacity Act 2005 allows others to act in that person’s best interests.

For the purpose of the Act a person lacks capacity if at the time a decision needs to be made they are unable to make a decision because of an ‘impairment of, or a disturbance in the functioning of, the mind or brain’. The impairment or disturbance may be permanent or temporary (Mental Capacity Act 2005, section 2).

Capacity can fluctuate and a person can have capacity for some decisions and lack capacity for others. For example, in the estate of Park [1953] a court held that a man who had suffered a debilitating stroke lacked capacity to make a valid will but had the capacity to marry on the same day. The court held that the complexity involved in making a will required greater capacity than agreeing to enter a marriage.

District nurses must therefore be aware that a person may have capacity for some decisions and lack capacity for other more complex decisions. All assessment of decision making capacity must therefore be in relation to the decision that needs to be made at the time rather than a general ability to make decisions.

Best interests

Where a person lacks decision making capacity then the Mental Capacity Act 2005 allows others to make decisions on their behalf in their best interests. Best interests are not defined by the Act, they depend on the individual circumstances of the person concerned. Instead the Act provides a checklist of common factors that must be taken into account before a judgement about best interests is made (Mental Capacity Act 2005, section 4). The process is now far more holistic and places the wishes, feelings, beliefs and values of the person at the centre of the decision.

Designated decision makers

The individual responsible for making a decision in the incapable person’s best interests is also significantly modified by the Mental Capacity Act 2005. Formal powers under the Act now allow a third party to make a proxy consent for a person who lacks capacity. This person is responsible for determining the best interests of the patient and a district nurse must ask their consent before proceeding with care and treatment.

This power may be granted by way of a personal welfare Lasting Power of Attorney (LPA) and can include the right to consent to treatment including life sustaining treatment on the incapable adult’s behalf.

The power may also be granted by the court of protection to a court appointed deputy (CAD) where the court finds that a person who lacks capacity needs a third party to make consent to treatment decisions on an ongoing basis on their behalf.

In the absence of a person with a formal power that allows them to consent to care and treatment on an incapable person’s behalf then the decision maker will be the person responsible for the care of the individual. This person may be a relative for day-to-day matters and a district nurse for the care and treatment the person requires. In more serious cases where more than one person is concerned with the care and treatment of the individual, then the person in charge of the person’s treatment will be the decision maker. This is usually the doctor in charge of the patient’s care. A doctor or district nurse’s ability to provide treatment in a person’s best interests may also be limited by a valid and applicable advance decision refusing treatment that allows a person to set out in advance the treatment they wish to refuse in particular circumstances, and this can include life sustaining treatment (Mental Capacity Act 2005, section 24).

Protection from liability

Where a district nurse complies with the requirements of the Mental Capacity Act 2005 then they are protected from liability in relation to the law of trespass to the person and so cannot be sued for unlawfully touching a patient.

Statutory principles of the Mental Capacity Act 2005

The law now allows a wide range of people to make decisions on behalf of those who lack decision making capacity. These include:

- Family
- Friends
- Health professionals
- Lawyers
- Judges.

This ensures that everyone who has to make a decision for a person who lacks capacity, applies the Act’s philosophy and standards. Section 1 of the Mental Capacity Act 2005 sets out five statutory principles (Table 1) that must be applied whenever decisions are made and actions taken under the Act.

District nurses must apply these statutory principles when caring for patients who lack decision making capacity.

**Principle 1: presumption of capacity**

‘A person must be assumed to have capacity unless it is established that he lacks capacity’ (Mental Capacity Act 2005, section 1(2)). Under English Law an adult has the right to make his or her own decisions and is assumed to have the capacity to do so, unless it can be shown otherwise (Airedale NHS Trust vs Bland [1993]). Respect for autonomy and self determination is now set out in the Act. Children who have attained the age of sixteen are entitled to be treated as if they were of full age with regard to consent to treatment (Family Law Reform Act 1969, section 8).

The presumption of capacity means that a district nurse is not required to assess the capacity of every patient in their care. An assessment is only required where the district nurse has some doubt about a person’s ability to make a decision.

**Principle 2: supporting a person to make a decision**

‘A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success’ (Mental Capacity Act 2005, section 1(3)). The 2005 Act recognizes that some people require assistance to make a decision. Decision making capacity is based on a test of understanding. Taking practical steps to assist a person in making a decision is a fundamental requirement of the Mental Capacity Act 2005. The code of practice suggests that such steps might include:

- **Using a different form of communication such as non-verbal communication**
- **Providing information in a more accessible form such as photographs, drawings or tapes**
- **Treating a medical condition which may be affecting the person’s capacity or**
- **Having a structured programme to improve a person’s capacity to make particular decisions such as helping a person with learning disabilities to learn new skills**
- **Waiting until the effect of drink or drugs have worn off before requiring a decision to be made.** Department for Constitutional Affairs 2007 at paragraph 2.7).

**Principle 3: An individual’s right to make unwise decisions**

‘A person is not to be treated as unable to make a decision merely because he makes an unwise decision’ (Mental Capacity Act 2005, section 1(4)).

The fact that a person makes an unwise decision or makes a decision that appears to be irrational to others must not be regarded as an inability to make decisions. The test for decision making capacity requires that there be an impairment or disturbance to the functioning of the person’s mind or brain. Where there is no discernible impairment or disturbance then it must be accepted that the decision may be an unwise decision, and is not an issue of a person’s ability to make a decision. For example, a woman refused a blood transfusion because of her religious beliefs shortly after giving birth to twins. Her decision may be viewed as unwise but one she was entitled to take as a capable adult (Attewill, 2007).

**Principle 4: Best interests**

‘An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests’ (S1(5)). This principle emphasizes that regardless of who makes a decision on behalf of an adult who lacks decision making capacity, the decision must be in the person’s best interests. This principle therefore allows a district nurse to challenge a decision made on behalf of an incapacitated person if they believe it is not in the person’s best interests. If the dispute cannot be settled locally then the Court of Protection can settle the matter. Where this is the case and treatment is required to sustain life then it may continue until the court makes its decision (Department for Constitutional Affairs 2007, chapter 5).

**Principle 5: Ensuring the least restrictive alternative**

‘Before an act is done, or a decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person’s rights and freedom of action’ (Mental Capacity Act 2005, section 1(6)).

This principle acknowledges that the need to assess capacity and determine best interests requires a nurse to interfere in the life of the person who lacks capacity, even though it is for the very best of reasons. The principle therefore reflects the key human rights concept of proportionality that requires any interference in the life of another to be the minimum necessary to achieve the needs of the individual. For example, the Mental Capacity Act 2005 allows the use of restraint where a person believes it is necessary to prevent harm to the person who lacks capacity. However, the restraint must be proportionate both to the risk of harm and the seriousness of the harm. Similarly before the court can appoint a person to act on behalf of an incapable person it must be satisfied that it cannot achieve the same end by use of a single order which would be less restrictive than giving a person ongoing decision making powers for the patient who lacks capacity.

**Conclusion**

The Mental Capacity Act 2005 applies whenever a district nurse believes that a person 16 years old or over is incapable of making a decision about an aspect of their life such as
care and treatment.

The Act places the incapable person at the centre of the decision making process through a statutory framework for assessing capacity and a checklist of factors that must be considered when determining best interests. The Mental Capacity Act 2005 addresses a perceived imbalance where too much decision-making power was traditionally vested in doctors and nurses by allowing a third party to make decisions on behalf of an incapable adult through the provisions of a personal-welfare lasting power of attorney or a deputy appointed by the court of protection. The wishes of a person to refuse treatment, even life sustaining treatment, when incapable have been given legal force through the advance decision refusing treatment.

To ensure that all individuals acting under the provisions of the Mental Capacity Act 2005 do so in a consistent manner the Act sets out five statutory principles that must be applied whenever decisions are made and actions taken under the Act. These principles are supported by a code of practice that provides guidance for district nurses and others in their use of the Mental Capacity Act 2005.

In next month’s article the concept of decision making capacity and the assessment of capacity will be considered and applied to district nursing practice.

KEYPOINTS

- The Mental Capacity Act 2005 represents the most significant development in the law relating people who lack decision making capacity since the Mental Health Act 1959 removed the state’s parens patriae jurisdiction preventing relatives, courts and government bodies consenting on behalf of incapable adults.
- The Mental Capacity Act 2005 impacts on the care and treatment provided by district nurses and it is essential that you have a sound working knowledge of its provisions and code of practice.
- Mental capacity is the ability to make a decision and is the key to a person’s autonomy.
- Formal powers under the Act now allow a third party to make a proxy consent for a person who lacks capacity.
- To ensure that everyone who makes a decision for a person who lacks capacity applies the Act’s philosophy and standards, the Act sets out five statutory principles that must be applied whenever decisions are made and actions taken under the Act.

Airedale NHS Trust v Bland [1993] AC 789
Attewill F (2007) Jehovah’s Witness mother dies after refusing blood transfusion Guardian pg 5 November 5th

F v West Berkshire HA [1990] 2 A.C. 1 (HL)
In the estate of Park [1993] 2 All ER 1411
Re T (Adult: Refusal of Treatment) [1992] 3 WLR
Re W (A Minor) (Medical Treatment: Court’s Jurisdiction) [1993] Fam 64 (CA)