Mental Capacity Act tool kit

BMA

ABOUT THIS TOOL KIT

In 2007 the Mental Capacity Act 2005 came into force in England and Wales. It provides a legal framework for decision-making on behalf of people aged 16 or over who cannot make decisions themselves. It also sets out the law for people who wish to make preparations for a time in the future when they may lack capacity to make decisions.

The purpose of this tool kit is to act as a prompt to doctors when they are providing care and treatment for people who lack, or who may lack, the mental capacity to make decisions on their own behalf. In the BMA's view, this is likely to be the majority of doctors. The tool kit consists of a series of cards relating to specific areas of the Act, such as how to assess capacity, the Act's basic principles, advance refusals of treatment, research and Lasting Powers of Attorney (LPAs). Although each of the cards refers to separate areas of the Act, there is inevitably a degree of overlap.

This tool kit is not intended to provide definitive guidance on all the issues surrounding the Mental Capacity Act. Card 1 lists alternative sources of guidance that should be used in conjunction with the cards. In cases of doubt, legal advice should be sought. The tool kit is designed to raise doctors' awareness of the Act, and to provide an aid for good decision-making.

This tool kit applies to England and Wales. In Scotland, decision-making in this area is covered by the Adults With Incapacity (Scotland) Act 2000. In Northern Ireland, decision-making is governed by the common law.

The tool kit is available on the BMA's website. NHS Trusts, medical schools and individual doctors may download and adapt it to suit their own requirements. There are no copyright restrictions on this tool kit – please feel free to make multiple copies.

The BMA would welcome feedback on the usefulness of the tool kit. If you have any comments please address them to:

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CARD 1

GUIDANCE ON THE MENTAL CAPACITY ACT

Publications

Advance decisions and proxy decision-making in medical treatment and research, British Medical Association (2007)

Assessment of mental capacity, British Medical Association and The Law Society (3rd edition due in 2008-9)

Medical ethics today: the BMA's handbook of ethics and law, British Medical Association (2004)

Medical treatment for adults with incapacity: guidance on medico-legal issues in Scotland, British Medical Association (2002)

Mental Capacity Act 2005 Code of Practice, Department for Constitutional Affairs (2007)

The impact of the Human Rights Act 1998 on medical decision-making, British Medical Association (2007)

The Mental Capacity Act – guidance for health professionals, British Medical Association (2007)

Making decisions – a guide for people who work in health and social care, Ministry of Justice and Office of the Public Guardian (2007)

CARD 2

GENERAL INFORMATION

1 The Mental Capacity Act 2005

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. The approach in Northern Ireland is currently governed by the common law.

The Act applies to all decisions taken on behalf of people who permanently or temporarily lack capacity to make such decisions themselves, 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. This tool kit sets out the main features of the Act in so far as it relates to decisions about medical treatment.

The Act is accompanied by a statutory Code of Practice providing guidance on how it should be used. Certain people have a legal duty to have regard to the guidance in the Code of Practice, including anyone acting in a professional capacity or being paid for their work with people who may lack capacity. It is therefore essential that health professionals are familiar with the Code of Practice.

2 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.

3 When does a person lack capacity?

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'. 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 is unable to make that particular decision?

The assessment of capacity is 'task-specific'. It focuses on the specific decision that needs to be made at the specific time the decision is required. It does not matter 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.

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.

CARD 3

BASIC PRINCIPLES

1 What are the Act's 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 best interests comes later in the tool kit.

2 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 who challenges it.

3 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. For example, advocates and communication support might be necessary, and consideration should be given to whether an individual's capacity is affected by the time of day or medication regimes. 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.

4 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. All adults retain the right to make decisions which to others might seem unwise or irrational. Although such actions may raise questions about capacity – where for example they follow a period of illness or an accident – they are in no way determinative. What matters is the ability to make the decision, not the outcome.

5 Best interests

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

6 The less restrictive alternative

Whenever a person is making a decision on behalf of an adult who lacks capacity, he or she must consider if it is possible to make the decision in a way that is less restrictive of that individual's fundamental rights or freedoms. There are often several ways to achieve a desired outcome, and where possible the choice must be the one that interferes least with the individual's freedoms while still achieving the necessary goal. The option chosen must, however, be in the person's best interests, which may not in fact be the least restrictive.

CARD 4

ASSESSING CAPACITY

1 Who should assess capacity?

The individual 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 is 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.

2 How do you assess capacity?

The Act makes use of a 'functional' test of capacity, adapted from the common law, which focuses on the decision-making process itself. First it must be established that the person being assessed has 'an impairment of, or a disturbance in the functioning of, the mind or brain' which may affect their ability to make the decision in question. 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 is unable:

- 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.

In assessing capacity, consideration should be given, where appropriate, to the views of those close to the individual. Family members and close friends may be able to provide valuable background information, although their views about what they might want for the individual must not be allowed to influence the assessment. An assessment that a person lacks the capacity to make a decision must not be discriminatory. It must not be based simply on a person's:

- age
- appearance
- assumptions about their condition
- any aspect of their behaviour.

3 Uncertainties about capacity

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. 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.

4 What do you do when an individual refuses 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.

CARD 5

BEST INTERESTS

1 What does the Act mean by best interests?

All decisions taken on behalf of someone who lacks capacity must be taken in his or her best interests. This is a statutory restatement of the previous common law position. The Act provides a checklist of common factors that must be taken into account when making a best interests judgement. A best interests judgement is not an attempt to determine what the person would have wanted, although this must be taken into account. It is as objective a test as possible of what would be in the person's actual best interests, taking into consideration all relevant factors.

2 What should you take into account when assessing best interests?

Lacking capacity to make a decision should not exclude an individual from participating in the decision-making process as far as is possible. The decision-maker must also take into account the likelihood that the person will regain capacity. A decision should be delayed if it can reasonably be left until he or she regains the capacity to make it. 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

- his or her beliefs or values where they would have an impact on the decision
- other factors the person would have considered if able to do so – such as the effect of the decision on other people.

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, bearing in mind the duty of confidentiality. (For more information on information sharing, see card 16.) It should also include anyone previously nominated by the person as someone to be consulted, anyone appointed to act under a Lasting Power of Attorney or any deputy appointed to make decisions by the Court of Protection. Further information about the last two is given later in the tool kit (see cards 11 and 12).

3 Are there any exceptions to the best interests principle?

There are two circumstances when the best interests principle will not apply. The first is where someone has previously made an advance decision to refuse medical treatment while they had capacity. Where the advance decision is valid and applicable, it should be respected, even if others think that the decision is not in his or her best interests. (For more information on advance decisions, see card 9.)

The second exception relates to the enrolment of incapacitated adults in certain forms of research. This is covered in more detail in card 10.

CARD 6

ACTS IN CONNECTION WITH CARE OR TREATMENT

1 What powers does the Act give to health professionals?

An action or intervention will be lawful – ie health professionals will enjoy protection from liability – where the decision-maker has a *reasonable belief* that the individual lacks capacity to consent to what is proposed, and that the action or decision is in his or her best interests. (See card 5 on how to assess someone's 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 to 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.

2 How far do these powers extend?

There are limits to these powers. 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 be proportionate to the risk, and of the minimum level necessary to protect the incapacitated person. (For more information about restraint, see card 7.)

The onus is on the person wishing to act to justify as objectively as possible 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. 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. (See cards 7 and 8 for more information on deprivation of liberty.)

3 When is court approval required?

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 sterilisation
- some termination of pregnancy cases

- cases where there is a doubt or dispute that cannot be resolved locally about whether a particular treatment will be in a person's best interests
- cases involving ethical dilemmas in untested areas.

CARD 7

RESTRAINT

1 What is restraint?

There may be occasions when health professionals need to consider the use of restraint in treating an individual lacking capacity. The Act states that restraint is the use or threat of force, to make someone do something they are resisting, or restricting a person's freedom of movement, whether they are resisting or not. The Act only refers to restraint to prevent harm to the patient. Health professionals have a common law right to use restraint to prevent harm to others.

2 Types of restraint

Restraint can be overt, such as the use of bedrails. It can also be covert and indirect such as doors that are heavy and difficult to open or putting patients in low chairs from which they find it difficult to move. Restraint may be:

- physical – held by one or more persons
- mechanical – the use of equipment such as bedrails, mittens to stop patients removing nasogastric tubes or catheters
- chemical – involving medication, for example sedation
- psychological – telling patients that they are not allowed to do something, or taking away aids necessary for them to do what they want, for example spectacles or walking aids.

3 When is restraint lawful?

Restrictive measures should be a last resort and alternatives to restraint must always be considered. Anybody proposing to use restraint must have objective reasons to justify that it is necessary. They must also be able to show that the patient is likely to suffer harm unless proportionate restraint is used. A proportionate response means using the least intrusive type and the minimum amount of restraint to achieve the objective, in the best interests of the patient lacking capacity. If these conditions are met, it is permissible to restrain a patient to provide necessary treatment. It also follows that in such circumstances there would be no liability for assault. The restraint must not amount to a deprivation of liberty and if it is considered necessary to go so far as to deprive someone of their liberty in order to safeguard their interests, special safeguards must be employed. (For further information on deprivation of liberty, see card 8.)

CARD 8

CARE AND TREATMENT AMOUNTING TO DEPRIVATION OF LIBERTY – THE 'BOURNEWOOD' SAFEGUARDS

1 Deprivation of liberty

The basic principles of the Mental Capacity Act make it clear that people who lack the ability to consent to treatment should be cared for in the least restrictive manner possible. There will be circumstances however in which appropriate care or treatment that is in an individual's best interests can only be provided in circumstances that will amount to a 'deprivation of liberty'. Following an amendment, the Mental Capacity Act now provides a set of safeguards that must be in place where an individual is deprived of liberty. These new safeguards come into effect in April 2009.

The concept of 'deprivation of liberty' is not straightforward and where doctors identify individuals who may be being deprived of liberty and who are not subject to mental health legislation, appropriate advice should be sought.

This card gives a brief outline of relevant factors to take into account when assessing whether an individual is or might be deprived of liberty. It looks at means of avoiding depriving people of liberty and at safeguards that must be in place when it cannot be avoided.

2 What is deprivation of liberty?

The courts have identified that the following factors are likely to result in deprivation of liberty:

- restraint is used, including sedation, to admit a person who is resisting
- professionals exercise complete and effective control over care and movement for a significant period
- professionals exercise control over assessments, treatment, contacts and residence
- the person would be prevented from leaving if they made a meaningful attempt to do so
- a request by carers for the person to be discharged to their care is likely to be refused
- the person is unable to maintain social contacts because of the restrictions placed on access to other people
- the person loses autonomy because they are under continuous supervision and control.

3 How can deprivation of liberty be avoided?

All individuals should be treated in ways that restrict fundamental freedoms as little as possible. Where a decision is made on behalf of an individual who lacks capacity, the decision must be the least restrictive of the available options, as long as that is in the person's best interests. Wherever possible, deprivation of liberty should be avoided. Active measures should be taken to avoid unnecessary restrictions, and decision-making should involve, as fully as possible, both the individuals and those who are close to them.

Good practice in this area will include the following:

- decisions should be taken and reviewed in a structured way and the reasons behind them recorded
- effective documented care planning, (which could include, where appropriate, the Care Programme approach, Single Assessment Process, Person Centred Planning or Unified Assessment), should be in place. This should include appropriate and documented involvement of the individual, their family, friends, carers or other people interested in their welfare
- proper documented assessment of whether the patient lacks the capacity to decide whether to consent to the care being proposed
- alternatives to admission to hospital or residential care should be carefully considered and any restrictions placed on liberty in care homes or hospitals should be kept to the minimum necessary
- appropriate information, presented in ways that are sensitive to individual needs, should be offered to patients and those involved in their care
- where appropriate, local advocacy services should be enrolled to provide support to patients and their families, friends and carers
- care should be taken to ensure as far as possible that the patient remains in contact with those close to him or her
- the assessment of the patient's capacity, and his or her care plan, should be kept under review.

4 How do you authorise deprivation of liberty?

Until the safeguards introduced in 2009, deprivation of liberty may be authorised either by using detention under the Mental Health Act (MHA), or if the grounds for MHA detention are not met, by applying to the Court of Protection.

After April 2009, when an individual lacking capacity is identified as being at risk of deprivation of liberty in a hospital or care home setting, the 'managing authority' of the hospital or care home has to make an application to a 'supervisory' body to request an authorisation of the deprivation. In the case of an NHS hospital, the managing authority will be the NHS body responsible for its running. In the case of a private hospital or care home, the managing authority will be the person registered, or required to be registered, under Part 2 of the Care Standards Act 2000. In England the supervisory body is the Primary Care Trust, if the patient is in hospital, or the local authority, if the patient is in a care home. In Wales it is either the National Assembly for Wales or a Local Health Board, or the relevant local authority for a patient in a care home. The application should be made in advance, except in urgent situations when the care home or hospital can issue an emergency authorisation, ensuring that the decision is documented. A standard authorisation must then be sought within seven days.

CARD 9

ADVANCE DECISIONS REFUSING TREATMENT

1 What is an advance decision?

The Act makes it clear that somebody who is aged 18 or over and has the necessary mental capacity can refuse specified medical treatment for a time in the future when he or she may lose the capacity to make the decision. This is known as an advance decision. The Act's powers are restricted explicitly to advance decisions to refuse treatment. An advance refusal of treatment is binding if:

- the person making the decision 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 decision has not withdrawn the decision at a time when he or she had the capacity to do so
- the person making the decision has not appointed, after the decision was made, an attorney to make the specified decision
- the person making the decision has not done anything clearly inconsistent with the decision remaining a fixed decision.

2 Can advance decisions extend to refusing life-sustaining treatment?

Although advance 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. Advance 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 decision, doctors can provide treatment that is immediately necessary to stabilize or to prevent a deterioration in the patient until the existence, and the validity and applicability, of the advance decision can be established.

3 Do advance decisions apply to individuals subject to compulsory mental health legislation?

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, save in the case of electro-convulsive treatment (ECT) although the treating professional should take such a decision 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 during periods of compulsion.

CARD 10

RESEARCH

1 Can patients who lack capacity participate in research?

It is lawful under the Act to involve adults who lack capacity in research (other than clinical trials into pharmaceutical products which is regulated by the Medicines for Human Use (Clinical Trials) Regulations 2004) provided it is related to the condition that contributes to the impairment of the mind or brain from which they are suffering. The research must be approved by 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 'therapeutic' and is expected to benefit the individual directly, the risks must not be excessive in relation to the anticipated benefits. Where the research is not expected to deliver direct benefit to the patients but is intended to investigate the condition from which they suffer, the risk to individuals must be negligible, and any intrusion kept to a minimum.

2 What are the safeguards for the individual who lacks capacity?

Before an incapacitated individual can be enrolled in research the researcher must identify someone close to them who is willing to be consulted about the appropriateness of

their involvement. In the absence of such a person, the researcher must nominate somebody who is independent of the research. RECs will provide guidance on this process.

There are additional safeguards once the research has started. Where the incapacitated individuals show signs of distress or resistance or indicate by any means the wish not to continue in the research, then they must be withdrawn. There are also Regulations under the Act which provide for the management and protection of an adult patient enrolled in a research project who loses capacity after the research has commenced.

3 Can research take place in an emergency situation where the patient lacks capacity?

In December 2006, an amendment to the UK's Medicines for Human Use (Clinical Trials) Regulations 2004 came into force. This allows unconscious patients to be enrolled in clinical trials of pharmaceutical products without prior consent in emergency situations provided the research has REC approval.

CARD 11

LASTING POWERS OF ATTORNEY

The Mental Capacity Act replaces the Enduring Power of Attorney (EPA) with a new form of power of attorney, a Lasting Power of Attorney (LPA). An LPA allows the individual (the donor) to give authority to someone else (the attorney) to make decisions on the donor's behalf. The donor decides who the attorney should be and how wide-ranging the power should be. More than one attorney can be appointed and they may be appointed to make some decisions jointly (ie together) and some decisions jointly and severally (ie independently). If the LPA does not specify this then the attorneys must act jointly.

There are two types of LPA, the property and affairs LPA and the personal welfare LPA. The personal welfare LPA covers personal, welfare and health care decisions, including decisions relating to medical treatment. Although an LPA in relation to property and affairs can be used by the attorney even when the donor still has capacity, an LPA dealing with personal welfare can only operate if the individual lacks capacity in relation to the issue in question.

1 Requirements of an LPA

The Act allows an individual aged 18 or over who has capacity to appoint an attorney under a personal welfare LPA, to make decisions on their behalf once they lose capacity. In order for it to be valid a specific

form must be used for an LPA. This must be in writing and include:

- information about the nature and extent of the LPA
- a statement signed by the donor stating that they have read and understood the information and that they want the LPA to apply when they lose capacity
- the names of anyone (other than the attorney(s)) who should be told about an application to register the LPA
- a statement signed by the attorney(s) stating that they have read the information and understand the duties, in particular the duty to act in the donor's best interests
- a certificate completed by a third party, confirming that, in their opinion, the donor understands the nature and purpose of the LPA and that no fraud or pressure has been used to create the LPA. Registered health care professionals can be certificate providers and, GPs in particular, may find they are asked by patients to fulfil this role.

2 Registration of an LPA

An LPA must be registered with the Office of the Public Guardian (OPG) before it can be used. It does not give the attorney any legal power to make decisions before it is registered. The OPG will maintain a register of LPAs and, where there is doubt as to the existence of an LPA, a health professional can apply to search the register. A fee is payable for this service.

3 Powers of an LPA

The powers granted to an attorney will depend entirely on the wording of the LPA. If a personal welfare LPA has been registered, the attorney will have no authority to make decisions about the donor's finances or property. On the other hand, if a property and affairs LPA has been registered, the attorney will have no power to make any decisions about the medical treatment of the donor. The donor may also have included specific restrictions on the attorney's powers. It is therefore important that health care professionals carefully check the wording of the LPA. Even where a general welfare LPA has been created and no restrictions have been imposed by the donor, an attorney cannot:

- make treatment decisions if the donor has capacity
- consent to a specific treatment if the donor has made a valid and applicable advance decision to refuse that treatment after the creation of the LPA
- consent to, or refuse, life-sustaining treatment unless this is expressly authorised by the LPA
- consent to, or refuse, treatment for a mental disorder where a patient is detained under mental health legislation
- demand specific treatment that health professionals consider is not necessary or appropriate for the donor's particular condition.

Where an attorney is acting under a personal welfare LPA and they are making decisions in relation to medical treatment, they must act in the donor's best interests. If there is any doubt about this and it cannot be resolved locally an application can be made to the Court of Protection (see also card 12).

4 LPA versus EPA

The fundamental difference is that EPAs cover decisions relating to property and financial affairs only, whereas there are two types of LPA, one to deal with financial affairs and one to deal with personal welfare and medical treatment decisions. An EPA cannot be created after 30 September 2007. However, EPAs created before that date can be registered and used after 1 October 2007. EPAs that are already registered will remain legally effective. LPAs will eventually replace the existing system of EPA, but this will inevitably take some years during which time the two systems will co-exist.

CARD 12

COURT OF PROTECTION AND COURT-APPOINTED DEPUTIES

1 Court of Protection

The Act has established a new Court of Protection to oversee the proper functioning of the legislation. The Court has the power to rule on the validity of LPAs as well as to determine their meaning or effect. It also has the power to rule on cases where there is doubt or dispute as to whether a particular treatment is in the best interests of an incapacitated individual, and to make a declaration as to whether an individual has or lacks capacity to make decisions. As was the position before the introduction of the Act the approval of the Court will still be required for the following:

- decisions about the proposed withholding or withdrawal of artificial nutrition and hydration from patients in a persistent vegetative state
- cases involving organ or bone marrow donation by a person who lacks capacity
- cases involving proposed non-therapeutic sterilisation of a person who lacks capacity
- cases involving ethical dilemmas in untested areas
- some termination of pregnancy cases
- cases where there is a doubt or dispute that cannot be resolved locally about whether a particular treatment will be in a person's best interests.

The Court of Protection has the same authority as the High Court and appeals can be made against its decisions, with permission, to the Court of Appeal.

2 Court-appointed deputies

The new Court of Protection is able to appoint deputies as substitute decision-makers where a person loses capacity and has not appointed an attorney under an LPA. Deputies replace and extend the previous role of a receiver. Receivers who were appointed before the Act came into force on 1 October 2007 automatically become deputies from that date.

Deputies can be appointed to make decisions on health and welfare as well as financial matters. They are likely to be appointed where an ongoing series of decisions is needed to resolve an issue, rather than a single decision of the court. In the majority of cases, the deputy is likely to be a family member or someone who knows the patient well. However, the Court may sometimes appoint a deputy who is independent of the family, if, for example, there is a history of serious family dispute or the individual's health and care needs are very complex.

As with attorneys appointed under an LPA, deputies have to make decisions in the individual's best interests and must allow the individual to make any decisions for which they have capacity. Deputies cannot refuse or consent to life-sustaining treatment.

Deputies should inform the health professional with whom they are dealing that the Court has appointed them as a deputy. Deputies will have been provided with official documentation in relation to their appointment. Health professionals should review the documentation in order to confirm the extent and scope of the authority given by the Court.

CARD 13

INDEPENDENT MENTAL CAPACITY ADVOCATES

1 What is an Independent Mental Capacity Advocate (IMCA)?

IMCAs support and represent particularly vulnerable adults who lack capacity to make certain decisions where there are no family members or friends available or willing to be consulted about those decisions. An IMCA is independent of the health care professional making the decision and represents the patient in discussions about whether the proposed decision is in the patient's best interests. An IMCA can also raise questions or challenge decisions which appear not to be in the patient's best interests.

2 When should an IMCA be instructed?

An IMCA must be instructed in relation to individuals who lack capacity and who have no family or friends whom it is appropriate to consult when:

- an NHS body is proposing to provide, withhold or stop 'serious medical treatment'; or
- an NHS body or local authority is proposing to arrange accommodation (or a change in accommodation) in a hospital or care home, and the stay in hospital will be more than 28 days, or the stay in the care home more than eight weeks.

Whilst it is not compulsory, IMCAs may also be instructed in a care review of arrangements for accommodation or an adult protection case involving a vulnerable individual, whether or not family members are involved.

An IMCA cannot be instructed if an individual has previously named a person who should be consulted about decisions that affect them, and that person is willing to assist, or they have appointed an attorney under a personal welfare LPA or the Court of Protection has appointed a welfare deputy to act on the patient's behalf. There is also no duty to instruct an IMCA where there is a need to make an urgent decision, for example, to save a patient's life. If a patient requires treatment whilst a report is awaited from an IMCA, this can be provided in the patient's best interests. It is also not necessary to instruct an IMCA for patients detained under mental health legislation.

Responsibility for instructing an IMCA lies with the NHS body or local authority providing the treatment or accommodation.

3 What is 'serious medical treatment'?

Serious medical treatment is defined as treatment which involves providing, withdrawing, or withholding treatment 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
- in the 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.

Examples of serious medical treatment might include chemotherapy and surgery for cancer, therapeutic sterilisation, major surgery, withholding or stopping artificial nutrition and hydration and termination of pregnancy. Where it is proposed to withdraw or withhold artificial nutrition and hydration from a patient in a persistent vegetative state, an application must be made to the Court of Protection (see card 12).

4 What are the powers of an IMCA?

In order to provide necessary support to the incapacitated individual an IMCA will have powers to:

- examine health records which are relevant and necessary to deal with the issue
- consult other persons who may be in a position to comment on the incapacitated individual's wishes, feelings and beliefs
- ascertain what alternative courses, actions and options may be available to the incapacitated individual
- obtain an alternative medical opinion.

An IMCA is required to write a report to the NHS body or local authority responsible for the individual's treatment or care. The IMCA's report must be taken into account before the final decision is made.

CARD 14

RELATIONSHIP WITH THE MENTAL HEALTH ACT

The relationship between the Mental Capacity Act (MCA) and the Mental Health Act (MHA) is a key issue for health professionals.

1 When is the MHA applicable?

The code of practice to the MCA states that before the MHA is used, consideration should be given to using the MCA instead. It also makes it clear that an individual does not lack capacity simply because they are subject to the MHA. However, health professionals should consider using the MHA to detain and treat an individual without capacity where:

- it is not possible to provide care or treatment without depriving the individual of his liberty
- the treatment cannot be given under the MCA, eg because of a valid advance decision
- restraint in a way that is not permitted by the MCA is required
- assessment or treatment cannot be undertaken safely and effectively other than on a compulsory basis
- the individual lacks capacity in respect of some parts of the treatment but has capacity in respect of other parts and refuses a key element
- there is another reason why the individual may not receive treatment and as a result the individual or someone else may suffer harm.

2 The MCA/MHA interface

As stated previously, except in the case of ECT, advance decisions relating to compulsory treatment under the MHA will not be binding. On the other hand, a valid and applicable advance decision for treatment for conditions that are not covered by the compulsory powers of the MHA will be lawful. 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 MCA.

There may be circumstances in which either legal framework may apply and the question as to which Act applies will be for the judgement of the health professional. However, as a rule of thumb if the patient retains capacity the MCA cannot be used. If the treatment is for a physical condition, then the MHA is irrelevant. If the treatment is for a mental disorder and the patient retains capacity, the MCA cannot be used. Where detention is deemed necessary, the MHA must be used provided the relevant grounds are met. Where the treatment amounts to a deprivation of liberty and the MHA cannot be used then the 'Bournewood' safeguards introduced in April 2009 should be considered (see also card 8).

CARD 15

DISPUTE RESOLUTION

There may be occasions in relation to the care and treatment of a person who may be incapacitated where disagreements arise. These may relate to:

- whether an individual retains the capacity to make a decision
- whether a proposed decision or intervention is in an incapacitated person's best interests
- whether the decision or the intervention is the most suitable of the available options.

It is clearly in everybody's interests that disagreements are resolved as soon as possible, and with as much consensus as possible. Broadly speaking, disputes can be resolved either informally or formally. Some disputes will be so serious that they may have to be referred to the Court of Protection. This card sets out briefly the different options available for resolving disputes in relation to incapacitated adults.

1 Good communication

Many disputes can either be avoided, or settled rapidly, by using good communication and involving all relevant individuals. Where health professionals are involved in a dispute with those close to an incapacitated person it is a good idea to:

- set out the different options in a way that

can be clearly understood
- invite a colleague to talk the matter over and offer a second opinion
- consider enrolling the services of an advocate
- arrange a meeting to discuss the matter in detail.

2 Mediation

Where the methods outlined above do not successfully resolve the dispute, it may be a good idea to involve a mediator. Any dispute that is likely to be settled by negotiation is probably suitable for mediation. A mediator is an independent facilitator. It is not the role of a mediator to make decisions or to impose solutions. The mediator will seek to facilitate a decision that is acceptable to all parties in the dispute. The following organisations can provide trained and accredited mediators:

The National Mediation Helpline: Tel: 0845 60 30 809 www.nationalmediationhelpline.com
Family Mediation Helpline: Tel: 0845 60 26 627 www.familymediationhelpline.co.uk

3 Patient complaints

It may be that as part of the dispute resolution process, those acting on behalf of an incapacitated adult might wish to lodge a complaint about the services he or she has received. Health professionals should be able to provide information about which complaint procedures would be appropriate in the circumstances. Initially the Patient Advice and Liaison Service (PALS) may be able to deal with the problem informally. PALS does not investigate complaints but they can, where

appropriate, direct people to the formal NHS complaints process.

4 The Court of Protection

The Court of Protection is the final arbiter in relation to matters arising under the Mental Capacity Act. The Court can make decisions about whether an individual has the capacity to make a specific decision. Where disputes have arisen that cannot be resolved in any other way, it may be necessary to make an application to the Court of Protection. Cases involving any of the following decisions should always be brought before the Court:

- decisions about the proposed withholding or withdrawal of artificial nutrition and hydration from patients in a persistent vegetative state
- cases involving organ or bone marrow donation by a person who lacks capacity
- cases involving proposed non-therapeutic sterilisation of a person who lacks capacity
- cases involving ethical dilemmas in untested areas
- some termination of pregnancy cases
- cases involving ethical dilemmas in untested areas
- all other cases where there is disagreement that cannot be resolved by other means as to whether a particular treatment will be in a person's best interests.

The Office of the Public Guardian can provide information about making an application to the Court of Protection. Tel: 0845 330 2900. www.publicguardian.gov.uk/index.htm

CARD 16

CONFIDENTIALITY AND INFORMATION SHARING

Health professionals have the same duty of confidentiality to all their patients regardless of age or disability. Patients with mental health problems or learning disabilities should not automatically be regarded as lacking capacity to give or withhold their consent to the disclosure of confidential information. In the case of health information, health professionals may only disclose information on the basis of the patient's best interests. Where patients lack mental capacity to consent to disclosure it is usually reasonable to assume that they would want people close to them to be given information about their illness, prognosis and treatment unless there is evidence to the contrary. However, where there is evidence that the patient did not want information shared, this must be respected. Those close to the patient who lacks capacity have an important role to play in decision-making whether they have a formal role as a proxy decision-maker (attorney or deputy), or more informally in terms of helping the health care team to assess the patient's best interests. It therefore might not be possible to carry out these roles without some information being provided about the medical condition of the patient.

1 Proxy decision-makers and IMCAs

Welfare attorneys and court-appointed deputies whose authority extends to medical decisions have the right to give or withhold consent to treatment and so must be involved in treatment decisions, although where emergency treatment is required this may not always be possible or practicable. Where a patient lacks capacity and has no relatives or friends to be consulted, the Act requires an Independent Mental Capacity Advocate (IMCA) to be appointed and consulted about all decisions about 'serious medical treatment', or place of residence (see also card 13). The health team must provide the attorney, deputy or IMCA with all the relevant information including the risks, benefits, side effects, likelihood of success and level of anticipated improvement if treatment is to be given, the likely outcome if treatment is withheld and any alternatives that might be considered. While it will therefore be necessary for attorneys, deputies and IMCAs to have information that will enable them to act or make decisions on behalf of the patient, it does not mean that they will always need to have access to all the patient's records. Only such information that is relevant to deal with the issue in question should be disclosed.

2 Relatives, carers and friends

If a patient lacks capacity, health professionals may need to share information with relatives, friends or carers to enable them to assess the patient's best interests. Where a patient is seriously ill and lacks capacity, it would be unreasonable always to refuse to provide any

information to those close to the patient on the basis that they have not given explicit consent. This does not however mean that all information should be routinely shared and where the information is particularly sensitive, a judgement will be needed about how much information the patient is likely to want to be shared and with whom. Where there is evidence that the patient did not want information shared, this must be respected.

3 Next of kin

Despite the widespread use of the phrase 'next of kin' this is neither defined, nor does it have formal legal status. A next of kin has no rights of access to a patient's medical records or to information on a patient's medical condition. On the other hand, if, prior to losing capacity, a patient nominates a next of kin and gives authority to discuss their condition with them, they can provide valuable information to the staff looking after the patient. There are no rules about who can and cannot be a next of kin. A patient may nominate their spouse, partner, member of their family or friend. A patient's family cannot argue who should be the next of kin if the patient has not made a nomination as there is no legal status attached to it. It is important not to confuse the concept of next of kin with the role of 'nearest relative' under the Mental Health Act. The individual authorised to undertake that role is subject to the statutory rules under that Act which is wholly distinct from any nomination of next of kin.

CARD 17

USEFUL NAMES AND ADDRESSES

British Medical Association
Medical Ethics Department
BMA House, Tavistock Square, London, WC1H 9JP.
Tel: 020 7383 6286, *Fax:* 020 7383 6233
Web: www.bma.org.uk/ethics

Ministry of Justice
Selborne House, 54 Victoria Street
London, SW1E 6QW.
Tel: 020 7 210 8500, *Web:* www.gsi.gov.uk

Department of Health
Wellington House
133-55 Waterloo Road, London, SE1 8UG.
Tel: 020 7972 2000, *Web:* www.doh.gov.uk

General Medical Council
Regents Place, 350 Euston Road
London, NW1 3JN.
Tel: 020 7189 5404, *Fax:* 020 7189 5401
Web: www.gmc-uk.org

Medical and Dental Defence Union of Scotland
Mackintosh House
120 Blythswood Street, Glasgow, G2 4EA.
Tel: 0141 221 5858, *Fax:* 0141 228 1208
Web: www.mddus.com

Medical Defence Union
230 Blackfriars Road, London, SE1 8PG.
Tel: 020 7202 1500, *Fax:* 020 7202 1666
Web: www.mdu.com

Medical Protection Society
33 Cavendish Square, London, W1G 0PS.
Tel: 0845 605 4000, *Fax:* 020 7399 1301
Web: www.mps.org.uk

Northern Ireland Department of Health, Social Services and Public Safety
Castle Buildings, Stormont, Belfast, BT4 3SJ.
Tel: 028 9052 0500, *Web:* www.dhsspsni.gov.uk

Nursing and Midwifery Council
23 Portland Place, London, W1B 1PZ.
Tel: 020 7637 7181, *Fax: 020 7 436 2924*
Web: www.nmc-uk.org

Office of the Public Guardian and the Court of Protection (England and Wales)
Archway Tower, 2 Junction Road
London, N19 5SZ.
Tel: 0845 330 2900, *Fax:* 020 7664 7705
Web: www.publicguardian.gov.uk

Office of the Public Guardian (Scotland)
Hadrian House
Callendar Business Park, Callender Road
Falkirk, FK1 1XR.
Tel: 01324 678300, *Fax:* 01234 678301
Web: www.publicguardian-scotland.gov.uk

Royal College of General Practitioners
14 Princes Gate, Hyde Park, London, SW7 1PU.
Tel: 020 7581 3232, *Fax:* 020 7225 3047
Web: www.rcgp.org.uk

Royal College of Nursing
20 Cavendish Square, London, W1M 0AB.
Tel: 020 7409 3333, *Fax:* 020 7647 3435
Web: www.rcn.org.uk

Royal College of Psychiatrists
17 Belgrave Square, London, SW1X 8PG.
Tel: 020 7235 2351, *Fax:* 020 7245 1231
Web: www.rcpsych.ac.uk

Scottish Government Health Directorate
St Andrew's House, Regent Road,
Edinburgh, EH1 3DG.
Tel: 0131 556 8400, *Fax*: 0131 244 8240
Web: www.scotland.gov.uk

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