Mental Capacity Legislation

This is an Act of Parliament which applies in England and Wales and came into force in April 2007. Its primary purpose is to provide a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves. Prior to the Act such decisions were made under common law and guided by previous case law. This lead to uncertainty in the rights and legal protection of patients and treating doctors alike.

Guiding principles

The Mental Capacity Act 2005 (MCA) is underpinned by 5 guiding principles which must be followed.

These are:

- an assumption of capacity
- supporting people to make their own decisions
- people have the right to make eccentric or unwise decisions
- where someone lacks capacity one must act in the person's best interests
- where someone lacks capacity any action taken on their behalf must generally be the least restrictive option

What is mental capacity and when might you need to assess capacity?

Having mental capacity means that a person is able to make their own decisions. One should always start from the assumption that the person has the capacity to make the decision in question (principle 1). One should also be able to show that every effort was made to encourage and support the person to make the decision themselves (principle 2). If a person makes a decision which is considered eccentric or unwise, this does not necessarily mean that the person lacks the capacity to make the decision (principle 3). Under the MCA, there is a requirement to make an assessment of capacity before carrying out any care or treatment – the more serious the decision, the more formal the assessment of capacity needs to be.

When should capacity be assessed?

There is a need to assess capacity where a person is unable to make a particular decision at a particular time because their mind or brain is affected by illness of disability. Lack of capacity may not be a permanent condition. Assessments of capacity should be time and decision specific. One cannot decide that someone lacks capacity based upon age, appearance, condition or behaviour alone.

Two-stage functional test of capacity

In order to decide whether an individual has the capacity to make a particular decision one must answer two questions:

Stage 1**.** Is there an impairment of or disturbance in the functioning of a person's mind or brain? If so,

Stage 2**.** Is the impairment or disturbance sufficient that the person lacks the capacity to make a particular decision?

The MCA says that a person is unable to make their own decision if they cannot do one or more of the following four things:

- understand information given to them
- retain that information long enough to be able to make the decision
- weigh up the information available to make the decision

- communicate their decision – this could be by talking, using sign language or even simple muscle movements such as blinking an eye or squeezing a hand.

Every effort should be made to find ways of communicating with someone before deciding that they lack capacity to make a decision based solely on their inability to communicate. Also, there is a need to involve family, friends, carers or other professionals.

The assessment must be made on the balance of probabilities – is it more likely than not that the person lacks capacity? It should be able to shown in records why capacity is lacking for the particular decision.

Best interests decision-making

If a person has been assessed as lacking capacity then any action taken, or any decision made for or on behalf of that person, must be made in his or her best interests (principle 4). The person who has to make the decision is known as the 'decision-maker' and normally will be the carer responsible for the day-to-day care, or a professional such as a doctor, nurse or social worker where decisions about treatment, care arrangements or accommodation need to be made.

What is 'best interests'?

The Act provides a non-exhaustive checklist of factors that decision-makers must work through in deciding what is in a person's best interests. A person can put his/her wishes and feelings into a written statement if they so wish, which the person determining capacity must consider. In addition, people involved in caring for the person lacking capacity have to be consulted concerning a person's best interests

Care and treatment under the MCA

The MCA gives legal protection to people who take actions and decisions in connection with the care or treatment of a person who lacks the mental capacity to deal with their own care or treatment. To be covered by this legal protection, the person taking the action or decision must establish that the other person lacks capacity in relation to the particular care or treatment and that the action or decision is in the person's best interests.

Restraint

The MCA allows a person who lacks capacity to make a particular decision to be physically restrained in order to prevent him or her from being harmed. The restraint must be proportionate to the likelihood of the person suffering harm and also to the seriousness of that harm. A useful example is someone who does not have the mental capacity to be aware of road safety. It would be acceptable for a relative or carer to physically stop the person from walking into the road. However, it would not be acceptable for the relative or carer to keep the person locked in at all times to prevent them going near traffic.

Planning ahead (1) - Lasting Powers of Attorney

The MCA introduced Lasting Powers of Attorney (LPA). These allow the person making the LPA (the donor) to give power 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. There are two types of LPA – the property and affairs LPA and a personal welfare LPA.

Property and affairs LPA

A property and affairs LPA covers issues such as the management of bank accounts and the buying or selling of a home. The donor can specify that the attorney(s) should only have the power to manage financial affairs after the donor loses capacity, sometime in the future. Otherwise, the attorney can use the LPA as soon as it has been registered with the Office of the Public Guardian (OPG), even if the donor still has capacity.

Personal welfare LPA

Until the MCA came into force people were only allowed to appoint attorneys to make financial decisions. Now people can make personal welfare LPAs that cover issues such as medical treatment, social care and where to live.

The donor of an LPA must be aged 18 or over and must have the mental capacity to make it. The LPA is made using a form that also contains a certificate that must be signed by an independent person to confirm that the donor fully understands what is involved in making the LPA and what having an LPA in place will mean for the donor. The person signing the certificate is also confirming that no fraud or undue pressure has been used to make the donor create the LPA.

Planning ahead (2) - Advance Decisions

An advance decision involves a person stating what types of treatment he or she does not want to be given if they ever lose the capacity to decide on this treatment. They are legally binding and must be followed by doctors and other health professionals, as long as they meet certain conditions.

An advance decision may be made by a person who is aged 18 years or over and who has capacity to make it. An advance decision must be in writing and witnessed if it applies to "life-sustaining treatment" (treatment which in the view of a person providing health care for the person concerned is necessary to sustain life). There are no formalities for making advance decisions that do not apply to life-sustaining treatment but it is probably better for people to write their decision down on paper.

An advance decision is not valid if the person has since withdrawn it, as long as that person had capacity to do so, or if the person has since made an LPA concerning the treatment to which the advance decision relates. An advance decision will also be invalid where the person who made it has since acted in a way that is clearly inconsistent with it. Where it is valid, a decision only comes into effect once the person concerned has lost capacity in relation to the decision(s) in question.

There are two important points to note about advance decisions:

1. A person cannot demand a particular treatment in an advance decision; they can only cover the types of treatments they would wish not to be given.
2. Advance decisions do not allow people to refuse to be detained ("sectioned") or treated without their consent under the Mental Health Act 1983. This is because as the law stands in England and Wales, people can be treated for "mental disorder" without their consent even if they have the mental capacity to make decisions about the treatment they are being given.

New Court of Protection

The MCA created a new Court of Protection to oversee actions taken under the Act and to resolve disputes that involve mental capacity matters. The Court has the same authority as the High Court and appeals can be made against its decisions, with permission, to the Court of Appeal.

The Court can-

- Make declarations as to whether a person has or lacks capacity to make a particular decision and to rule whether an act that is being proposed in relation to a person is lawful or not.
- Make decisions and appoint deputies to make decisions on a person's personal welfare as well as on property and affairs.
- Make decisions in respect of personal welfare.

Amendments

In response to the ruling by the European Court of Human Rights in HL v UK (2004) (the 'Bournewood' judgment) the Act was amended by the Mental Health Act 2007 in July that year. These additions are known as the 'deprivation of liberty safeguards', and were implemented in April 2009. These amendments created a range of administrative and legal safeguards to protect the rights of adults who lack capacity who are, or may be, deprived of their liberty in care homes or hospitals.

Capacity and the Law in Malaysia

The Mental Health Act 2001 which was enacted in 2010 contains a section dealing with capacity assessment for surgery, ECT and taking part in clinical trials in those deemed to be mentally disordered. It states consent for the above may be given –

a) 'By the patient himself if he is capable of giving consent as assessed by a psychiatrist
b) By his guardian in the case of a minor or relative in the case of an adult, if the patient is incapable of giving consent;
c) By two psychiatrists, one of whom shall be the attending psychiatrist, if there is no guardian or relative of the patient available or traceable and the patient himself is incapable of giving consent. '

If there is an emergency need for ECT or surgery consent maybe given by the guardian or relative or two medical practitioners if no relative is available.

When assessing whether a mentally disordered person is capable of giving consent 'the examining psychiatrist shall consider whether or not the person examined understands-

a) the condition for which the treatment is proposed;
b) the nature and purpose of the treatment;
c) the risks involved in undergoing the treatment;
d) the risk involved in not undergoing the treatment; and
e) whether or not his ability to consent is affected by his condition'.

The Act states that other than for surgery, ECT or participation in clinical trials, 'no consent is required for other forms of conventional treatment'. Unlike the various UK legislations there is no need to get consent for psychiatric medication.

In practise in Malaysia in the general hospital setting, there is use of the legislation for procedures other than surgery when dealing with an individual lacking capacity who needs treatment.

Key comparisons of mental capacity legislation between Malaysia and England and Wales.

	England and Wales Mental Capacity Act 2005	**Malaysia MHA 2001 (Enacted 2010)**
Definition of mental disorder	Yes - broad	Yes - broad
What treatment is included	All that is beyond the remit of the Mental Health Act	Surgery, ECT and participation in clinical trials.
Who can assess	All doctors - a psychiatric opinion may be sort in complex cases	Psychiatrist
Who can decide	The patient Health care professional Court	The patient A relative 2 psychiatrists
Best interests test	Yes and extensive guidance	No
Advanced decisions	Yes - extensive legal framework	No clear legal framework
External review	CQC - for quality issues Court of protection for legal issues.	Board of Visitors

Mental capacity legislation- Scenarios

Scenario 1- Giving appropriate advice and support

Sara, a young woman with severe depression, is getting treatment from mental health services. Her psychiatrist determines that she has capacity to make decisions about treatment, if she gets advice and support.

Her mother is trying to persuade Sara to agree to electro-convulsive therapy (ECT), which helped her mother when she had clinical depression in the past. However, a friend has told Sara that ECT is 'barbaric'.

The psychiatrist provides factual information about the different types of treatment available and explains their advantages and disadvantages. She also describes how different people experience different reactions or side effects. Sara is then able to consider what treatment is right for her, based on factual information rather than the personal opinions of her mother and friend.

In either the England and Wales or Malaysia she could not be treated if she had capacity and was not subject to the mental health act. If she lacked capacity she could be treated under the MHA in England and Wales after a second opinion doctor had been to see her. In Malaysia if she lacked capacity she could be treated if her mother gave consent, again under the Malaysian Mental Health Act.

Scenario 2 – Best interests

Pedro, a young man with a severe learning disability, lives in a care home. He has dental problems, which cause him a lot of pain, but refuses to open his mouth for his teeth to be cleaned. The staff suggest that it would be a good idea to give Pedro an occasional general anaesthetic so that a dentist can clean his teeth and fill any cavities. His mother is worried about the effects of an anaesthetic, but she hates to see him distressed and suggests instead that he should be given strong painkillers when needed.

While the views of Pedro's mother and carers are important in working out what course of action would be in his best interests, the decision must *not* be based on what would be less stressful for them. Instead, it must focus on Pedro's best interests.

The dentist concludes that it would be in Pedro's best interests for:

• a proper investigation to be carried out under anaesthetic so that immediate treatment can be provided

• options for his future dental care to be reviewed by the care team, involving Pedro as far as possible.

The dentist is able to do this under the MCA in England and Wales. In Malaysia such a procedure would have to be undertaken under the MHA. It could be carried out if his mother gave permission, if she did not, the treatment could be given after the agreement of two psychiatrists.

Scenario 3 - Deciding whether to use the MHA or MCA

Mrs Carter is in her 80s and has dementia. Somebody finds her wandering in the street, very confused and angry. A neighbour takes her home and calls her doctor. At home, it looks like she has been deliberately smashing things. There are cuts on her hands and arms, but she won't let the doctor touch them, and she hasn't been taking her medication.

Her doctor wants to admit her to hospital for assessment. Mrs Carter gets angry and says that they'll never keep her in hospital. So the doctor thinks that it might be necessary to use the MHA.

In the England and Wales he arranges for an approved social worker to visit. The social worker discovers that Mrs Carter was expecting her son this morning, but he has not turned up. They find out that he has been delayed, but could not call because Mrs Carter's telephone has become unplugged. When she is told that her son is on his way, Mrs Carter brightens up. She lets the doctor treat her cuts – which the doctor thinks it is in her best interests to do as soon as possible. When Mrs Carter's son arrives, the social worker explains the doctor is very worried, especially that Mrs Carter is not taking her medication. The son explains that he will help his mother take it in future. It is agreed that the MCA will allow him to do that. The social worker arranges to return a week later and calls the doctor to say that she thinks Mrs Carter can get the care she needs without being detained under the MHA. The doctor agrees.

In Malaysia the doctor would not need a social worker to detain the patient, they would simply sign a Form 4 if the relative had signed a Form 3 and the treating doctors at the psychiatric hospital would review the detention within 24hrs. If she remained at home, there is no legal framework in Malaysia to give her the medication at home if she lacked capacity.

Scenario 4 - Using the MCA to treat a patient who is detained under the MHA

Mr Peters is detained in hospital under a treatment section of the MHA. Mr Peters has paranoid schizophrenia, delusions, hallucinations and thought disorder. He refuses all medical treatment. Mr Peters has recently developed blood in his urine and staff persuaded him to have an ultrasound scan. The scan revealed suspected renal carcinoma. His consultant believes that he needs a CT scan and treatment for the carcinoma. But Mr Peters refuses a general anaesthetic and other medical procedures.

In England and Wales the consultant assesses Mr Peters as lacking capacity to consent to treatment under the MCA's test of capacity. The MHA is not relevant here, because the CT scan is not part of Mr Peters' treatment for mental disorder. Under section 5 of the MCA, doctors can provide treatment without consent. But they must follow the principles of the Act and believe that treatment is in Mr Peters' best interests.

In Malaysia, the treatment could be given under the Mental Health Act if a relative gave permission or if no relative is available, the treatment could be given after the agreement of two psychiatrists- one of which could be the treating psychiatrist.

Scenario 5 - Deciding on whether to follow an advance decision to refuse treatment

Miss Khan gets depression from time to time and has old physical injuries that cause her pain. She does not like the side effects of medication, and manages her health through diet and exercise. She knows that healthcare staff might doubt her decision-making capacity when she is depressed. So she makes an advance decision to refuse all medication for her physical pain and depression.

A year later, she gets major depression and is detained under the MHA. Her GP (family doctor) tells her psychiatrist at the hospital about her advance decision. But Miss Khan's condition gets so bad that she will not discuss treatment. So the psychiatrist decides to prescribe medication for her depression, despite her advance decision. This is possible because Miss Khan is detained under the MHA. This would apply in both England and Wales and Malaysia though in the former it is regulated though parts of the MHA. There is no statue around advance decisions or giving medication in Malaysian law.

In England and Wales the psychiatrist also believes that Miss Khan now lacks capacity to consent to medication for her physical pain. He assesses the validity of the advance decision to refuse medication for the physical pain. Her GP says that Miss Khan seemed perfectly well when she made the decision and seemed to understand what it meant. In the GP's view, Miss Khan had the capacity to make the advance decision. The psychiatrist decides that the advance decision is valid and applicable, and does not prescribe medication for Miss Khan's pain – even though he thinks it would be in her best interests. When Miss Khan's condition improves, the consultant will be able to discuss whether she would like to change her mind about treatment for her physical pain.

In Malaysia there is no statue around advance decisions or giving medication in the law so the psychiatrist could give the medication if he chose to do so. He might not do this after listen to the GP but there is no legal framework to apply around these decisions.