

The Mental Capacity Act 2007 and capacity assessments: a guide for the non-psychiatrist

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ABSTRACT – The Mental Capacity Act 2007 affects doctors in all areas of practice. The act recognises that capacity is a ‘balance of probability rather than certainty’, and based on this it attempts to ‘maximise capacity’ in an individual, so to facilitate a decision-making process. The act comprises five key principles as well as a test to determine lack of capacity. It also alludes to areas such as consent by proxy, restraint and capacity, and regulations regarding clinical research. This paper provides a brief background into the fundamental tenets of the act as well as a simple scheme for assessing capacity in hospital inpatients. It also looks at what physicians should be aware of and what will be required of them, particularly from a medico-legal perspective.

KEY WORDS: capacity, consent, living will, Mental Capacity Act 2007

Introduction

In April 2007 the UK government published the Mental Capacity Act (MCA) 2007 which replaces previous legislation (MCA 2005) and will significantly alter the ethos in which capacity to accept or reject treatment is assessed. Previously, treatment of patients was covered by various pieces of legislation, including the Mental Health Act (MHA) 1983, but the new act allows, for the first time, for a proxy to proceed on behalf of an incompetent patient. It should be noted that only in exceptional circumstances (prior to receiving electroconvulsive therapy, psychosurgery, or sex hormone implantation) does the MHA 1983 consider capacity and its assessment in detained individuals. In essence, the MCA 2007 incorporates five basic principles:

- an adult patient has the right to make their own (treatment) decisions, and is assumed to be capable of making these decisions unless there is proof to the contrary
- patients are entitled to the appropriate means of support they need to make their own decisions, before being considered incapable of making these decisions
- patients have the right to make decisions which may differ from those of their carers, healthcare

professionals or other involved parties provided that they have capacity to do this – it is capacity, not the decision, that is under scrutiny

- actions and interventions for individuals judged to lack capacity should be in their best interests
- actions and interventions for individuals judged to lack capacity should, as much as possible, not restrict their constitutional rights and freedoms.

The literature contains a number of studies considering capacity and its assessment in both medical and psychiatric patients; among the former, Raymont *et al*¹ found that 40% of acutely unwell patients lacked capacity while in the latter, reported figures vary from 20%² to 43.8%.³ Factors related to lack of capacity included cognitive impairment¹ and psychosis² although presence of the latter did not necessarily suggest a lack of ability to consent to treatment.

An important concept to consider is the actual definition of capacity, as it clearly depends on a number of socio-political paradigms. In usual parlance, capacity may be thought of as a general concept referring to the ability of a patient to make competent treatment decisions. Due to the number of variables which may affect the determination of capacity, a definition supplied by Applebaum and Grisso is perhaps more definitive:

*Competent decision making according to the appreciation standard requires recognition that one is suffering from disorder and that the generally accepted risks and benefits of treatment apply to one's own situation...failures in appreciation often are considered to be core components of major psychiatric disorder.*⁴

In real terms, capacity may be considered as the patient's ability to make autonomous decisions about their medical management. In essence, this consists of four basic components: being able to understand the relevant information, retain the information, evaluate the information as part of a decision-making process and communicate the decision.

Key principles of the Mental Capacity Act 2007

The first key principle of the MCA 2007 is that individuals above the age of 16 years are presumed to

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have capacity, unless proven otherwise. This supports the individuals' right to make treatment decisions, even if they appear to be irrational to the treating clinician.

■ **Capacity until proven otherwise: as an example, refusal of a life-saving blood transfusion by a competent Jehovah's Witness may seem an unwise decision but does not necessarily indicate lack of capacity.**

Assessment of capacity is a decision-specific process; although a person may have, for example, a history of dementia, they may still have the capacity to make valid decisions on specific treatments or other care interventions.

The second key principle suggests that the individual must be given all practicable steps to make their own decision.

■ **Provision of all practicable input to support independent decision making by patient: for example, a person with a severe speech impediment or elective mutism is likely to still have full mental capacity, but may encounter difficulty in communicating a decision thus all steps should be taken in order to establish a mode of communication.**

Principle of best interests

Another key principle of the act is that decisions made on behalf of an incapacitated person must be made in their 'best interests'. In order to determine this, the MCA defines a 'statutory checklist' which should be followed (Box 1).

Box 1. Statutory checklist to determine 'best interests'.

- In cases of 'fluctuating capacity' (eg in an acute confusional state) whether or not a person may regain capacity and, if so, when?
- Maximum involvement of the individual in the decision-making process
- A persons' past beliefs, values and wishes must be taken into consideration
- The decision made on behalf of the patient is the least restrictive and most acceptable mode of management
- All other relevant circumstances need to be considered (including relevant written statements)

In cases where the clinician feels it justified to act in the patient's best interests, an assessment must be made by the clinician directly responsible for the patient and any supporting views of other involved professionals (eg the liaison psychiatrist) should also be carefully documented. Views of the general practitioner, carer, appointed family member or, if necessary, other third party involvement should also be canvassed (after gaining permission from the patient or their proxy) and documented appropriately.

■ **Example of 'best interests': in an incapacitated patient with a gangrenous leg requiring amputation, as long as the surgeon acts in accordance with the statutory checklist and in the patient's best interests, he is not**

guilty of assault. In the same way he would not have been guilty of assault if the patient had capacity prior to the procedure and had provided informed consent for the operation.

Capacity and restraint

The common law Doctrine of Necessity still stands in the MCA 2007. However, as per the MHA 1983, a person can only be treated against their will if it is for a mental illness or if the patient is 'mentally impaired', but not directly for a physical health disorder. The MCA 2007 does not implicitly refer to physical restraint, which should only be used as a last resort in extreme circumstances by trained, competent practitioners. It should be noted that in rare cases physical restraint can result in medical morbidity and even death and decisions related to the use of physical restraint should therefore always be carefully considered, remembering the principle of 'best interests'.⁵

Third party involvement

The MCA 2007 differs from previous legislation in that it will, for the first time, allow a proxy to act on behalf of a patient deemed unable to make informed decisions regarding their medical care. Three aspects of the act are pertinent here, namely lasting power of attorney (LPA), the role of the independent mental capacity advocate (IMCA) and the new Court of Protection (CP).

Lasting power of attorney. The person appointing an LPA is deemed the 'donor', and makes this decision in advance of becoming incapacitated. The person accepting this responsibility is deemed the 'donee' and must be above 18 years of age at the time of designation. This individual must act in accordance with the 'best interests' statutory checklist, and can only make healthcare decisions once the donor has become incapacitated. Furthermore, the individual with LPA must be registered with the Court of Protection.

Independent mental capacity advocate. In cases where there are no next of kin or carer to speak on behalf of an incapacitated person, the court of protection is able to appoint a deputy, known as the independent mental capacity advocate (IMCA).

Court of Protection. The Court of Protection will have new powers, overtaking responsibilities previously dealt with by the high court. These are usually cases where irresolvable challenges present themselves. The court, on behalf of an incapacitated person, can:

- make healthcare decisions, based on best interests
- make decisions regarding property and financial affairs
- decide the validity of an LPA or advance directive
- decide the future placement of a person.

■ **Possible intervention by the Court of Protection: Consider the hypothetical case of a lady diagnosed with a**

severe depressive episode with severe suicidal ideation on a background of multiple medical co-morbidities (ischemic heart disease, morbid obesity, chronic obstructive pulmonary disease), requiring electroconvulsive therapy (ECT) under general anaesthetic (ie a high-risk procedure in context of co-morbidities).

She is stable, but refusing treatment and is felt to be unable to provide informed consent. She is a widow but has two sons, with conflicting opinions regarding treatment with ECT, she has no living will or appointed LPA. Involvement of the Court of Protection will allow the clinician to arrive to a management decision, based on best interests for the patient and protecting all parties involved in the decision-making process.

In cases of dispute over potentially life-sustaining treatment, action can be taken until the court provides a ruling.

Advanced refusals (also referred to as advanced directives or living wills)

Treatment can only be refused and not demanded based on an advanced directive (AD). The AD should be formulated and recorded when the patient is deemed to have capacity. The process should have two witnesses, ideally both independent, and the patient in question should not be subject to coercion.

To be effective, an AD must be valid and applicable; it is not valid if the directive has been subsequently withdrawn or the patient has knowingly acted in a manner contrary to the decision (for example, a change of opinion in the absence of possible confounding factors). In addition, it will not be considered valid if it has subsequently been withdrawn by the LPA.

An AD is not applicable if the patient has capacity to make the decision themselves at the time of treatment, the treatment has not been specified or unanticipated circumstances arise which are likely to have influenced the decision.

Research and capacity

The MCA 2007 states that research involving incapacitated patients should be strictly regulated. Involvement of the appropriate ethical bodies (for example, the local research and ethics committee) is required and the patient should agree to be involved. Advice and input should be sought from family/carers/other parties suggesting that the incapacitated patient would be happy to be involved if they had capacity.

How to assess capacity in a medical setting (adapted and extended from Reference⁶)

Figure 1 summarises the main steps in performing a capacity assessment. Note that in order to assess capacity, the exact reason(s) and possible courses of action for requesting capacity must be delineated. The relative pros and cons must be carefully considered, and the patient should be provided with this

information in order to assist in making an informed decision.

Capacity assessments are usually requested when a patient is actively refusing treatment or may have difficulty in making a decision regarding care. The latter may be related to several factors, most notably cognitive impairment or the presence of a mental disorder, learning difficulties or personality factors/individual reactions to stress. Any coercion, either overt or covert, must also be considered. Note that the presence of any of the above factors need not necessarily in itself negate the ability of the individual to make specific decisions regarding medical assessment, care, input or treatment.

Ideally patients should be seen in a quiet, non-threatening location, with bleeps turned off and a lack of interference from excessive noise, presence of others or any additional sources of distraction. Sufficient time should be set aside for the assessment. Prior to seeing the patient the assessor should consider confounding factors, which may interfere in decision-making processes, especially delirium. In some cases the assessment may need to be postponed until the confounding factor has been suitably alleviated. Where there is concern regarding the presence of mental illness such as a psychotic or mood disorder, discussion with the liaison psychiatry team may be beneficial.

When assessing mental capacity, four key questions need to be considered:

- 1 *Whether the patient is able to understand information pertaining to the decision about to be made.* This requires an appreciation of the patient's intelligence and basic understanding of why a decision needs to be made. This will require a thorough sharing of information in an open and non-selective manner. The use of aids, such as diagrams and leaflets, may be appropriate.
- 2 *Whether the patient is able to retain that information.* Simple means of assessing this include asking the patient to repeat what has been said, asking the patient to summarise important points of the discussion and periodically asking appropriate questions to test retention of relevant points.
- 3 *Whether the patient is able to use the information or consider the pros and cons of making a decision.* This requires thorough and clear explanations of risks, benefits, side effects, possible outcomes and other pertinent information.
- 4 *Whether the patient is able to communicate that decision.* This will use some of the same techniques as in 2 (above) and should indicate understanding and appreciation of what has been discussed, rather than mere repetition of facts.

In order for the capacity assessment to be properly conducted the patient must be supplied with all relevant information as summarised by the Department of Health⁷ and the General Medical Council.⁸ In brief, when providing information, the patient's beliefs, culture and other individual factors need to be considered. Being ready and willing to discuss matters rather than making assumptions will avoid conflict and enable patients to make a more informed decision. Information provided to patients should be given in ordinary language and explanations expressed simply and concisely. Information patients may wish

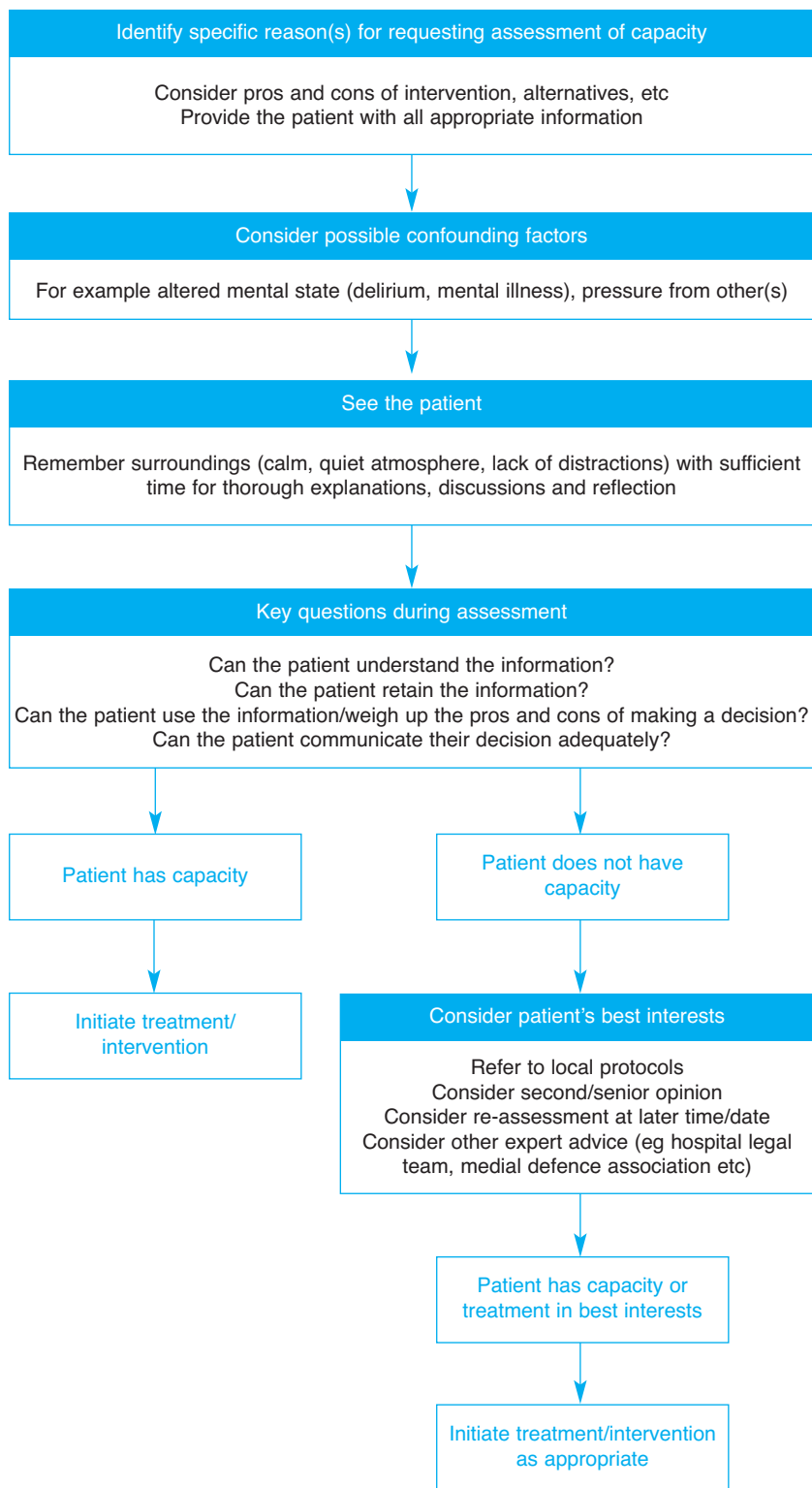


Fig 1. Suggested algorithm for performing capacity assessments.

to know before consenting to an investigation or treatment may include some or all of the following:

- the purpose of the proposed investigation/therapy
- any specific preparation that may be required
- a thorough description of what the procedure entails
- common after- and side effects (including possible long-term lifestyle changes)
- management approaches for these possible effects
- probability of success and failure
- where there is diagnostic uncertainty, details of further interventions
- details of diagnosis and prognosis, and likely prognosis if condition is left untreated.

The doctor responsible for treatment should remember that the patient may change their mind about consent and have a right to seek a second opinion.

In exceptional circumstances (such as in the unconscious patient), decisions to treat may fall outside the scope of the patient’s consent. In order to avoid the decision being challenged it may be wise to forewarn the patient of such possibilities. If in doubt, consult an experienced colleague before proceeding. Always be prepared to explain and justify your decision at a later stage, and always ask patients whether they have understood the information. An opportunity for the patient to ask questions should always be provided. There may be a number of outcomes following capacity assessment, ranging from clear-cut cases with either no or full capacity, to grey cases where there is some doubt about the outcome. In these cases it is reasonable to obtain a second opinion, either from a senior colleague or from a liaison psychiatrist.

For all capacity assessments, clear and precise documentation should be kept, including details of the assessor, the date, time and place of the assessment. The reason for the assessment must be documented, in addition to details regarding the patient’s current physical/mental state, what questions were asked, what the replies were, and how the presence, or lack, of capacity decision was arrived at.

When it is felt that the individual lacks capacity, as per the terms of the MCA 2005,

the best interests of the patient must be considered. This will involve careful consideration of the patient's wishes, those of carers/informants, advice from senior colleagues and local protocols. A second opinion may be appropriate, as may advice from other members of the multidisciplinary team such as social workers. In non clear-cut cases, advice from the hospital's legal team or from the assessor's medical defence service may be needed.

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