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CHAPTER 1

Introduction

Rebecca Jacob and Anthony Holland

In April 2005, the Mental Capacity Act 2005 (MCA), which relates to England and Wales, received Royal Assent, coming into force during 2007. The MCA incorporates into statute law principles and practice that had been established, over many years, through case law. It sets out how mental capacity is defined in law and how 'best interests' should be ascertained when a person lacks the requisite capacity to make the decision in question.

Prior to its introduction, clinicians and carers were in uncertain legal territory when making decisions of a social, medical or financial nature for individuals without capacity. Importantly, however, the Act is more than a solution to a recognised gap in English and Welsh law; it is also about a culture change. It requires those in a caring and/or professional capacity to engage with a person who may lack decision-making capacity, in a manner that involves the person and others important to them in the process of decision-making and has regard to their past and present beliefs and values. The MCA, in its approach, is not so much giving power to others to make decisions, rather it is asking those who have to take a decision on behalf of another to do so in a manner that is transparent, justifiable and respectful of all issues relevant to that person. It is applicable in any situation where someone might lack capacity, from a person transiently incapacitated through excess alcohol or from a head injury requiring treatment, to people with potentially more enduring incapacity due to dementia or intellectual disabilities. It is therefore as relevant in intensive care as it is in social care. The MCA is about the 'here and now', when an immediate decision may have to be made on behalf of a person lacking capacity at the time, but also about planning for the future – how individuals, while they have capacity, can determine who can take decisions on their behalf in the event that they later lose capacity through illness or injury.

Although it was a very significant Act of Parliament, much of what the MCA has brought into practice is what practitioners and others should already have been adhering to on the basis of the developing case law. In its early development work, the Law Commission, a statutory body set up to promote the reform of law in England and Wales, stated that people should be 'enabled and encouraged to take for themselves those decisions they are able to take' (Law Commission, 1991: p. 110). The pivotal concept when determining whether or not the MCA is applicable is therefore whether or

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not the person having to take the decision has the requisite decision-making capacity. This concept of 'capacity' is defined in the dictionary quite simply as 'the ability or power to do'. In a legal and/or clinical context, this might refer to an individual's ability to make a decision regarding a healthcare matter, undertaking the process of making a will or deciding where to live – in other words, decisions encompassing the social, welfare and health needs of an individual (British Medical Association Ethics Department, 2012).

This book draws on experience gained during the first few years that the MCA has been in force and also considers the Deprivation of Liberty Safeguards (DoLS) amendments to the MCA, which came into force in 2009. It is aimed at psychiatrists and other mental health professionals who treat individuals who lack capacity, and also those called upon to guide and advise colleagues in acute hospitals and residential care settings about the assessment of capacity, DoLS and the appropriate use of best interests principles. In addition, the book considers clinical exemplars in the application of the functional assessment of capacity and highlights medico-legal conundrums faced in the everyday application of the statute.

This first chapter gives an overview of the fundamental ethical and philosophical thinking that has shaped the MCA and a brief description of its historical development and scope. It also compares and contrasts the remit of the Mental Capacity Act 2005 with that of the Mental Health Act 1983 (MHA) as amended in 2007, since there are specific situations when, arguably, either Act might be applicable. Although the Human Rights Act 1998 is not formally dealt with, either in this chapter or in the book as a whole, its principles are clearly interwoven into the fabric of both Acts.

Medical ethics

A book on the Mental Capacity Act would be incomplete if it made no mention of the guiding principles that have come to underpin medical practice and this statute – sometimes referred to as the 'bioethical' approach. This is concerned with the framework within which a medical decision may be reached on the basis of an individual's views, values and wishes (Harris, 1985), and also how conflicts and dilemmas might be resolved when there are disagreements. Such conflicts may be as extreme as whether or not to start or to continue specific treatments for life-threatening illnesses. However, in essence the clinical situation is described as follows: the doctor advises on the treatment options, taking into account the patient's condition, prognosis and other relevant external factors. The patient, on due consideration, may or may not decide to accept the proposed treatment(s). The moral imperative remains with the doctor, using their medical expertise, to consider all the appropriate steps to seek to diagnose and treat the medical condition and to give the patient sufficient information to make a choice. Even though the competent patient has the absolute right to accept or refuse the treatments offered (except in the case of the assessment and treatment of a mental disorder, where the Mental Health Act might be used to override the refusal of a competent person), barring the most exceptional circumstances, the patient cannot demand a particular treatment (Harris, 1985).

Although a detailed discussion of the philosophical approaches that underlie the development of bioethics is beyond the scope of this book, it is appropriate to consider the theories that have influenced current medical practice. Various ethicists have put forward ideas based on different philosophical principles that have focused on either the rightness or wrongness of the act itself (deontological or Kantian theories), or the extent to which the act promotes good or even bad consequences (utilitarianism). In the former, the essential message is that we should respect an individual's right to autonomy and that each person is treated as an end in themselves, rather than as a means to an end. Deontological theories are concerned less with the consequences or outcome of any act than with the factors that make it morally acceptable, thereby upholding the integrity and beliefs of the individual. In contrast, utilitarianism highlights the moral dilemmas faced when considering the outcome of an act, i.e. the extent to which it leads to positive or negative consequences. This implies that the moral worth of an action is determined only by its resulting outcome. The utilitarian measure of a positive outcome, therefore, is the maximisation of happiness (Mason & Laurie, 2006).

Drawing on these and other philosophical theories, Beauchamp & Childress (2001) have suggested the concept of 'principlism' as a way to resolve medical ethical dilemmas. They broadly argue that the justification for our actions should be based on accepted values. They suggest that ethically appropriate conduct is determined by reference to four key principles, which are to be taken into account when reflecting on one's behaviour towards others. These are:

- the principle of respect for individual autonomy (i.e. individuals must be viewed as independent moral agents with the 'right' to choose how to live their own lives)
- the principle of beneficence (i.e. one should strive to do good where possible)
- the principle of non-maleficence (i.e. one should avoid doing harm to others)
- the principle of justice (i.e. people should be treated fairly, although this does not necessarily equate with treating everyone equally).

The principles of beneficence and non-maleficence are by no means new concepts and their origins extend to the Hippocratic Oath, which states:

> 'I will prescribe regimens for the good of my patients according to my ability and judgement and never do harm to anyone.'

According to advocates of the four-principles approach, one of its advantages is that, because the principles are independent of any particular

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philosophical theory, theorists working in a variety of different traditions can use them. However, this approach has been criticised on the basis that it does not offer any clear way of prioritising between the principles in cases where they conflict, as they are liable to do (Savulescu, 2003). The principle of autonomy, for example, might conflict with the principle of beneficence in cases where a competent adult patient refuses to accept life-saving treatment, as will be highlighted in the next section. How then can a medical practitioner respect a patient's right, in this case to allow their life to end, while simultaneously striving to do good, where possible, and at least avoid doing any harm? Current ethical thinking, which is moving away from paternalistic medical practice, indicates that, regardless of the consequences of the treatment, the treatment provider must accept the decision of the recipient. Yet this may not be applicable in all cases, most importantly where a patient does not have the capacity to decide. For this reason, greater clarity is needed regarding the circumstances under which each particular principle takes precedence. Despite these limitations, the principles remain useful as a framework within which to think about moral dilemmas in medicine and the life sciences.

Autonomy *v.* beneficence

The central notion on which informed choice and the importance of decision-making capacity is based is the principle of autonomy. 'Autonomy' has been variously defined but, in this context, implies self-determination. People are autonomous to the extent that they are able to control their own lives by exercising their own cognitive abilities. The acknowledgement of autonomy has served, in part, to overthrow medical paternalism and has led to the elevation of the patient from being a recipient to being an equal partner in a treatment plan (Kirby, 1983).

In the context of the delivery of healthcare, ethicists consider respect for an individual's autonomy as morally required because it is that individual's life and well-being which are at stake in medical treatment. Respect for human dignity entails that individuals should ultimately determine what their well-being consists of, and therefore what should or should not be done to them in order to achieve it. This conception of autonomy clearly implies that the patient has a 'self' which is capable of determining what should or should not happen – that is, they have a set of values, the sense of what is or is not in their own interests, which may be described as the their 'own' values (Harris, 1985). In prioritising an individual's values, clinicians recognise the importance of the patient's views on illness, dying, death, goals for the future and personal relationships, when making healthcare decisions. These values are highly personal and likely to result from the patient's own experience of life and their own reflections on that experience.

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The significance of self-determination and the weight placed on autonomous choice by the courts is clearly evident in case law. As Lord Donaldson stated in the case of *Re T (Adult)* [1992]:

> 'As I pointed out at the beginning of this judgment, the patient's right of choice exists whether the reasons for making that choice are rational, irrational, unknown or even non-existent. That his choice is contrary to what is to be expected of the vast majority of adults is only relevant if there are other reasons for doubting his capacity to decide.'

Although it is evident that contemporary medical and legal practices broadly embrace the concept of autonomous choice of the individual, it is important to bear in mind that full autonomy and autonomous choices are ideal concepts, which we can, realistically, only attain in partial measure. This is due to factors that may compromise an individual's autonomy, including: difficulties in reasoning, which may be temporary or permanent; the inadequacy and uncertainties of the information available to inform choice; and fluctuations in the stability of an individual's wishes (Harris, 1985). There are also other limitations to the claims of autonomy, such as economic and financial constraints – a fair distribution of resources would clearly not allow unrestricted rights to a single individual. Personal choice must therefore be viewed in the context of the needs of a community as a whole. Notwithstanding these limitations, both the ethical and legal duty lies with the healthcare professional to ensure that these impairments and limitations are minimised when initiating medical interventions.

Consent and the doctrine of necessity

It is a requirement of English law – specifically the law pertaining to assault and battery – that consent must be obtained before any treatment or procedure involving the patient can be lawfully carried out. This is clearly expressed in a statement by Justice Kirby:

> 'Nowadays doctors, out of respect for themselves and for their patients, (to say nothing for deference to the law) must increasingly face the obligation of securing informed consent from the patient for the kind of therapeutic treatment proposed' (Kirby, 1983).

Therefore, as a general rule medical treatment, even of a minor nature, should not proceed unless the doctor has first obtained the patient's consent, which may be either expressed or implied. There are nonetheless exceptions to the above rules that are essentially to do with situations such as unconsciousness, where consent cannot be obtained, or disability of the mind or brain, where the person lacks the capacity to make the decision. Until the passing of the MCA, the principle applied to treatment in these cases was that of the necessity doctrine. The basis of this doctrine is that acting out of necessity in the best interests of a patient operates as an alternative defence to that of consent, which remains the preferable defence.

Although the doctrine of necessity arose in relation to emergencies, in many cases this defence could be used when there is not an emergency in the ordinary sense of the word – rather, when the usual defence (i.e. consent) is not available but the treatment is still necessary.

The application of the doctrine of necessity has been clarified by two Canadian cases in which the courts clearly differentiated the overwhelming need for a particular treatment from the mere expediency of such an intervention. In the first case, *Marshall v Curry* [1933], the plaintiff sought damages against a surgeon who had removed a testicle in the course of an operation to repair a hernia. The surgeon stated that the removal was essential to the patient's health and life, as the testicle was diseased. The court held that the removal of the testicle was therefore necessary and could not be done at a later date. In the case of *Murray v McMurchy* [1949], however, the plaintiff succeeded in an action of battery against a doctor who had sterilised her without her consent. In this case, the doctor had discovered, during a Caesarean section, that the condition of the plaintiff's uterus would have made it hazardous for her to go through another pregnancy and he took the decision to tie the fallopian tubes. As there was no pressing medical need for the procedure to be undertaken, the court held that it would have been reasonable to postpone the procedure until the patient's consent could be obtained.

Thus, medical emergencies are not an exception to the process of obtaining consent purely by virtue of their need for either an urgent or an expedient decision to be made. Minimum interventions to preserve life are expected in emergencies, but if there is an expectation that capacity to make a decision may improve, case law, and now statute, require that the healthcare professional consider a delay in treatment if, on medical grounds, it is reasonable and possible to do so. Therefore, prior to the MCA, although consent was legally imperative for all treatment, if that consent was not possible and the intervention was necessary, urgent and/or in the patients' best interests, the doctrine of necessity could justify action in specific clinical situations. When applying this doctrine of necessity, it also had to be demonstrable that treatment could not have waited for the capacity of the individual to recover. It is this concept that is now codified in the MCA. A surgeon working in England and Wales faced now with either of the above dilemmas and a patient who clearly lacks capacity because under a general anaesthetic would have to follow the best interests process, unless urgent and life-saving action is required and the intervention cannot wait. Consequently, it is good practice for surgeons to seek their patients' views as to what they might wish to be done in the event of possible, but unexpected, clinical situations arising while they are under general anaesthetic.

In the UK, current medical and legal thinking incorporates the above approaches to bioethics in resolving ethical dilemmas in the practice of healthcare delivery. This is clearly reflected in emerging legislation, not only in the MCA, which embodies in statute the rights of a competent adult to

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make decisions for themselves, but also in other legislation, including the Adults with Incapacity (Scotland) Act 2000 and the 2007 amendments to certain aspects of the Mental Health Act 1983, with proposals for more options of community care and less restrictive treatments. These legislative changes go some way in addressing the principles proposed by Beauchamp & Childress (2001) of autonomy, justice, beneficence and non-maleficence.

Development of mental capacity legislation

Scotland was the first country in the UK to formally enact legislation to enable substitute decision-making under particular circumstances. This is set out in the Adults with Incapacity (Scotland) Act 2000. In England and Wales, development of capacity legislation was driven by a number of factors, including the needs of professionals and carers who required guidance on taking medical, social or financial decisions for people whom they recognised as unable to take such decisions for themselves. One case in particular, *Re F (Mental Patient: Sterilisation)* [1990], stimulated debate about the role of the courts in medical decisions. *Re F* involved the medical sterilisation of a woman lacking mental capacity, who was sexually active and whose family were concerned about an unintended pregnancy. The courts ruling in favour of sterilisation stated that doctors have the power and, in certain circumstances, the duty to treat incapacitous patients provided that the treatment is in their best interests. In this instance, an unplanned pregnancy was not considered to be in F’s best interests. Some argued, however, that *Re F* went too far in turning the question of incapacity into a purely medical decision based on the doctrine of necessity. The concern was that ‘leaving medical decisions solely to the medical profession might imply that they were to be taken only on medical criteria’ (Hoggett, 1994). Hoggett further argued that certain decisions are so important that a court, or at least an independent forum of some sort, should make them.

The reform put forward by the Law Commission in the 1990s focused on the fact that people should be enabled to make decisions for themselves but, under certain conditions, and where it is necessary and in their best interests, someone else should be in a position to make decisions on their behalf. It was recognised that individuals regularly face a wide variety of decisions, in areas ranging from medical and dental treatment, to property and affairs, and broadly how to carry out the activities of everyday life. Most adults can and should make such decisions for themselves, but the Law Commission pointed out that people who are vulnerable and lack capacity should be protected against exploitation in such matters. In a consultation paper titled *Mentally Incapacitated Adults and Decision-Making: An Overview* (Law Commission, 1991), it recommended the introduction of a single, comprehensive piece of legislation to make new provision for people who lack mental capacity. The broad values or aims set out in this consultation paper included the following principles:

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- people should be enabled and encouraged to take for themselves decisions that they are able to take
- where it is necessary in their own interests or for the protection of others that someone else should take decisions on their behalf, the intervention should be as limited as possible and concerned to achieve what they themselves would have wanted
- safeguards should be provided against exploitation, neglect and physical, sexual or psychological abuse.

This consultation resulted in the publication of the Green Paper *Who Decides?*, which set out how those without capacity should have the necessary assistance in their decision-making (Lord Chancellor's Department, 1997). The document included recommendations of the Law Commission published in its report on mental incapacity (Law Commission, 1995). The Lord Chancellor's Department received over 4000 responses to this Green Paper, from many sources: charities working for people at risk of lacking capacity; local authorities; doctors; professional organisations; and those working in the law. In light of these responses, the report *Making Decisions* (Lord Chancellor's Department, 1999) set out the Government's proposal to 'reform the law in order to improve and clarify the decision-making process for those who are unable to make decisions for themselves, or who cannot communicate their decisions'. The subsequent Mental Incapacity Bill was examined by a Joint Committee appointed to conduct pre-legislative scrutiny before it went to the floor of both Houses of Parliament for consideration. This Committee, having taken written and oral evidence, made a number of recommendations, including a change from 'Incapacity' to 'Capacity' in the title, a requirement for advocates, and the need for the Act to address the complex issue of research involving people lacking the capacity to consent to participation. The Government accepted many of the recommendations and the Mental Capacity Act received Royal Assent on 7 April 2005, just before the dissolution of Parliament for the general election.

The broad aims of the Law Commission reforms are now embodied in statute. The key principles that underpin the use of the MCA are stated in section 1 of the Act as follows:

> 'A person must be assumed to have capacity unless it is established that he lacks capacity.
>
> A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
>
> A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
>
> An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
>
> Before the act is done, or the decision made, regard must be had to whether the purpose for which it is needed can be affectively achieved in a way that is less restrictive of the person's rights and freedom of action.'

Summary of the provisions of the MCA

The provisions of the MCA are discussed in detail in Chapter 4 of this volume, but here we give a brief introduction to some of the significant changes that came about with the Act. The MCA deals broadly with two specific scenarios. The first involves 'acts in connection with care and treatment', in which individuals who lack the capacity to make particular decisions that it would normally be for them to make need those decisions to be made on their behalf. The second concerns the process of competent individuals planning for the future in the event of later incapacity through illness or injury. This involves the following options:

- **Lasting powers of attorney** The MCA allows a person to appoint someone, called an 'attorney' or 'donee', to act on their behalf if they should lose capacity in the future. This is not dissimilar to the previous enduring power of attorney in relation to property and affairs, but the lasting power of attorney also allows people to empower an attorney to make health and welfare decisions.
- **Advance decision-making** In addition to giving professionals and carers legal rights and obligations to ensure that care is provided for those without capacity, the MCA makes provisions for patients to have their own specific wishes respected if they lose capacity. This is addressed by the 'advance decision to refuse treatment'. A person can express their wish as to what should happen if they lose the capacity to make a particular healthcare decision. Advance decisions that state a wish for some particular treatment or other action must be considered, but are not necessarily legally binding. For example, a person cannot insist on something that is impossible when the time comes (e.g. wanting to live with someone who could not or does not wish to care for them), or is medically inappropriate or harmful (e.g. a treatment that is inappropriate for the illness in question). However, valid and applicable advance decisions to *refuse* treatment are legally binding, as they represent an extension of the individual's right to refuse treatment when having capacity.
- Another important development is the introduction of independent mental capacity advocates (IMCAs) for those who have not made a lasting power of attorney. An IMCA can speak on behalf of individuals who are without family or friends to represent their ascertainable wishes. The purpose of the IMCA service is to help vulnerable people who, while lacking capacity, require decisions to be made. Such decisions may range from serious medical treatment to a change of residence – for example, moving to a hospital or care home. National Health Service bodies and local authorities have a duty to consult an IMCA in certain decisions involving people who have no family or friends. An IMCA, unlike a donee under a lasting power of attorney,

cannot make a final decision on behalf of a patient; however, they offer independent advice to the professional bodies regarding what they believe is in the patient's best interests.

- During the process of legislative reform, the Law Commission had considered the need for an integrated statutory jurisdiction for making personal, welfare, healthcare and financial decisions on behalf of those lacking capacity and for resolving disputes through a new court system. The importance of this area of jurisdiction was emphasised in the setting up of the Court of Protection, which has jurisdiction relating to the whole MCA. The Court of Protection has the remit of being the final arbiter in matters related to mental capacity, best interests, lasting powers of attorney and other matters in connection with interventions provided for those without capacity to make specific decisions. It deals with decisions concerning property and affairs, as well as health and welfare. It is particularly important in resolving complex or disputed cases involving, for example, whether someone lacks capacity or what is in their best interests. The Court is based in venues in a number of locations across England and Wales and is supported by a central administration in London.
- A new Public Guardian has been created under the MCA. The Public Guardian has several duties and is supported in these by the Office of the Public Guardian. The Office of the Public Guardian is the registering authority for lasting powers of attorney and deputies appointed by the Court of Protection. It also supervises Court of Protection deputies and provides information to help the Court make decisions. The Office of the Public Guardian works together with other agencies, such as the police and Social Services, to respond to any concerns raised about the way in which an attorney or deputy is operating.

The Mental Health Act and the Mental Capacity Act: overlapping and differentiating criteria

Mental health professionals are perhaps in a unique position in having to observe statute and the Codes of Practice of both the MHA (Department of Health, 2008) and the MCA (Department for Constitutional Affairs, 2007), despite the fact that these two Acts are, debatably, based on different and potentially conflicting principles. The MCA respects the principle of autonomy for capacitous adults and sets out best interests principles regarding the care and treatment of adults who lack capacity to make decisions for themselves. The MHA enables treatment of mental disorder in non-consenting patients, whether or not they have capacity, a fact which has been considered by many to be discriminatory (Department of Health, 1999). The MHA is largely concerned with the circumstances in which a

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person with a mental disorder can be compulsorily detained for treatment of that disorder. It also sets out the processes that must be followed and the safeguards for patients, to ensure that they are not inappropriately detained in hospital. Using a rather broad description of the purpose of the legislation, it is to ensure that a person with a serious mental disorder can be 'detained in the interests of his own health or safety or with a view to the protection of other persons' (MHA: section 2).

Notwithstanding the many distinctions, there is some commonality in the defining criteria of the two Acts. The MCA defines an individual as lacking capacity 'if at the material time he is unable to make a decision for himself in relation to a matter because of an impairment of, or disturbance in the function of, the mind or brain', and the MHA defines a mental disorder simply as 'any disorder or disability of the mind'. Overlapping principles relate to the requirement to use the least restrictive alternative when considering care and to minimise restrictions on liberty. Both statutes enable clinicians to care for patients who need medical interventions and who either cannot (because of incapacity) or will not, in the case of the MHA, agree to the necessary intervention. The legislation takes into account the wishes of the nearest relative, family or friends, and requires that independent mental capacity advocates and independent mental health advocates are available to speak on behalf of vulnerable individuals if there is no one else to do so, although the final arbiter always remains the treating clinician.

The significant differences therefore relate to the condition for which treatment is required. When health professionals are dealing with the treatment of a mental disorder, mental health legislation (i.e. the MHA) usually, but not always, takes precedence over mental capacity legislation (the MCA and DoLS). When dealing with physical or non-psychiatric treatment of a patient without capacity, mental health legislation, via the MCA, is applicable.

Table 1.1 summarises some of the key legal, and clinical, differences between the two Acts and circumstances under which one or the other might apply (Dimond, 2008).

Occasionally, there is debate as to which of the legal statutes applies, and emerging case law suggests that in several instances, the Court of Protection's opinion is required to provide clarity. *GJ v The Foundation Trust and Others* [2009] is a case in point. Mr GJ, who had diagnoses of vascular dementia, Korsakoff's syndrome due to alcohol misuse, and diabetes, was initially detained in hospital under the MHA for treatment of his mental disorder. In due course, the hospital felt that it would be more appropriate to treat him under mental capacity legislation (as he was primarily receiving nursing care and treatment for his diabetes) and a standard authorisation for DoLS was made. An application was made to the Court of Protection to decide whether he was ineligible to be dealt with via the MCA DoLS on the grounds that his circumstances fell more properly within the scope

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Table 1.1 Main clinical and legal differences between the Mental Capacity Act 2005 and the Mental Health Act 1983 (as amended in 2007)

	Mental Capacity Act (MCA)	**Mental Health Act (MHA)**
Mental capacity	The MCA applies only to those who are unable to make specific decisions	The MHA does not require a lack of capacity
Mental disorder	MCA applies only to people with mental disorder who lack the capacity to make the decision in question	The MHA applies only if the patient requires assessment and/or treatment for mental disorder as defined by the Act
Best interests	The MCA requires that all decisions be made in the patient's best interests	The MHA does not require decisions to be made in the best interests of the patient and detention may be required for the protection of others
Range of treatments	The MCA enables whatever care and treatment is considered to be in the best interests of the patient	The MHA authorises only the administration of treatment for mental disorder, but this has a wide definition and may include feeding and basic care
Protections available	The MCA provides protection via the Court of Protection, but an application has to be made to trigger its jurisdiction	The MHA has a wide range of protections, including mental health review tribunals (MHRTs) and managers with responsibilities for making applications to an MHRT if the patient has not done so
Restraint	The MCA enables only limited restraint in narrowly defined circumstances (it originally did not permit a loss of liberty within the definition of Article 5 of the Human Rights Act, but this proviso was repealed in the MHA to fill the 'Bournewood gap'[a] and a loss of liberty under the MCA is now possible if the DoLS process has been approved)	The MHA provides the legal framework within which a patient can lose their liberty and be restrained lawfully without any contravention of Article 5 of the Human Rights Act
Decision-making if capacity is lost	The MCA recognises several devices for ensuring that decisions are made in accordance with the wishes of a person when they had the requisite mental capacity, to cover situations when capacity is lost; these include advance decisions and lasting powers of attorney	The MHA takes into account advance decisions. Clinical decisions are the responsibility of the responsible clinician; in certain circumstances where a person is unable or unwilling to give consent to treatment for a mental disorder, a second medical opinion must be sought before the treatment can be given

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a. The Bournewood gap is discussed in Chapter 5.

of the MHA and that he was actively objecting to treatment. The judge resolved the dilemma by clarifying that, if it were not for the treatment of his physical problems, the patient would not be detained; thus, the only reason for detention was for physical treatment. Clearly, this is not within the scope of MHA legislation and the judge held that, although GJ could not be detained under DoLS authorisation purely for the treatment of his mental disorder, he could be so detained in order to receive care and treatment for his physical disorder (diabetes). Consequently, he was eligible to be deprived of his liberty and the MCA rather than MHA was the more appropriate statute in this case.

The judge also highlighted, as a general point, that:

> 'the MHA 1983 has primacy in the sense that the relevant decision makers under both the MHA 1983 and the MCA should approach the questions they have to answer relating to the application of the MHA 1983 on the basis of an assumption that an alternative solution is not available under the MCA'.

It is therefore important that treating clinicians are familiar with the underlying principles of the MCA 2005 and the MHA 1983 and the different clinical situations within which each legislative framework can be applied.

Conclusion

The MCA is an enabling statute that allows a shift from paternalism towards respect and support of the individual's right to self-determination. However, this shift has highlighted the plight of people who might not consent to treatment, not because they do not want it, but because their mental disability interferes with their decision-making or their ability to communicate a choice. It would clearly be absurd if such people did not receive treatment because they lacked the relevant capacity. Such a situation would open the door to exploitation, neglect and abuse of vulnerable people whose actions and behaviours are compromised owing to unconsciousness, confusion or other reasons, either temporary or permanent. Yet, how can this be resolved without resort to a simplistic approach that equates incapacity to the presence of a particular diagnosis or some other status? And how can those empowered to act in such situations be supported to do so in a way that still respects, as far as possible, individual choice and dignity? It is these issues that the subsequent chapters of this book address in greater detail.

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