MENTAL CAPACITY ACT 2005

The Mental Capacity Act 2005 received the Royal Assent on 7 April 2005, and is likely to come into force on 2 April 2007. Queen's Printer's copies of the Act can be obtained from The Stationery Office for £9 (ISBN 0-10-540905-7). An Internet version can be found at http://www.hmso.gov.uk/acts/acts2005/20050009.htm

Separate explanatory notes are also available from The Stationery Office, and an online version can be downloaded from http://www.opsi.gov.uk/acts/en2005/2005en09.htm

A Code of Practice will provide further guidance (s 42). A preliminary draft code was prepared in September 2004 to assist Parliament while it was considering the Bill, and can be found at http://www.dca.gov.uk/menincap/mcbdraftcode.pdf

Some books on the Act have already been published. For example:

- Peter Bartlett, *Blackstone's Guide to the Mental Capacity Act 2005*, (Oxford University Press, ISBN 0199289034, price £29.95);
- Richard Jones, *Mental Capacity Act Manual*, (Thomson, Sweet & Maxwell, ISBN 0421918209, price £35);
- Nicola Greaney, Fenella Morris, and Beverley Taylor, *Mental Capacity Act 2005: A Guide to the New Law* (The Law Society, ISBN 1853289035, price £39.95).

Why the new legislation was necessary

The new legislation was needed for the following reasons:

- the inadequacies of the present common law, particularly the lacuna that arose as a result of the Mental Health Act 1959 whereby the *parens patriae* jurisdiction ceased to exist for adults lacking capacity, and the development of the High Court's declaratory jurisdiction to plug the gap.
- the need to promote awareness and good practice in dealing with those lacking capacity.
- the government's duty to fulfil human rights obligations towards those lacking capacity.
- the government's commitment to promote non-discrimination; and
- the need to achieve a better balance between autonomy and protection for people who are unable to make decisions.

The principles

If you read them in sequence, the principles in section 1 of the Mental Capacity Act form a flowchart or blueprint of how we should deal with people who are unable to make decisions for themselves in relation to a particular matter at a particular time because of an impairment of, or a disturbance in the functioning of, their mind or brain.

- 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 practical 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 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 is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

To these principles can be added the statements in sections 2(3) and 3(1) that, when deciding whether a person lacks capacity, and, if so, when determining what is in his best interests, it should not be established merely on the basis of:

- the person's age or appearance, or
- a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about his capacity, or what might be in his best interests.

Assessing capacity

Sections 2 and 3 set out the requirements for assessing whether someone lacks capacity. "A person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or disturbance in the functioning of the mind or brain"; s 2(1). Accordingly, capacity is both:

- "time-specific", focussing on the particular time when a decision has to be made – so the loss of capacity can be temporary, partial, or fluctuating, and
- "decision-specific", concentrating on the particular matter to which the decision relates, rather than the ability to make decisions generally. So, someone may lack capacity in relation to one particular matter, but not necessarily another.

The inability to make a decision must be caused by a temporary or permanent impairment of or disturbance in the functioning of the mind or brain. This is known as the "diagnostic threshold". The actual test for capacity is a "functional test" that looks at the decision-making process as a whole. A person who satisfies the diagnostic threshold is unable to make a decision for himself if he is unable to:

- understand the information relevant to the decision, including information about the reasonably foreseeable consequences of (a) deciding one way or another, or (b) failing to make the decision; wherever necessary, the information should be explained to him in a way that is appropriate to his circumstances, such as using simple language or visual aids;
- retain that information, though the fact that he is able to retain the information for only a short period does not prevent him from being regarded as able to make the decision;
- use or weigh that information as part of the process of making the decision; or

- communicate his decision, whether by talking, using sign language or any other means.

An good illustration of the practical application of some of these principles can be found in *Re AK (Medical Treatment: Consent)* [2001] 1 FLR 129:

> AK, who was 19, suffered from motor neurone disease, and for the last two years had been kept alive on a ventilator. For the last three months his only means of communicating was through moving one eyelid, by means of which he was able to answer questions with a 'yes', by the minimal movement of his eyelid, or 'no' by the absence of any movement of his eyelid. Using this method of communication, he had asked his mother, and subsequently the doctors treating him, to remove the ventilator two weeks after he lost the ability to communicate. He was aware that this would result in his death, and the doctors treating him sought a declaration that it would be lawful to discontinue the treatment in accordance with AK's directive. On 10 August 2000 Mr Justice Hughes granted the declaration sought.
>
> From a practical point of view, the interesting feature of this case is the communication difficulties, and the strenuous efforts that were taken to establish that AK understood the nature and effect of his decision to refuse medical treatment. On 3 August 2000 two specialists, a consultant anaesthetist and a consultant in palliative care, visited him. Mr Justice Hughes described their visit as follows: "Under careful questioning of a kind which I am satisfied took considerable pains to ensure they received only definitive and certain answers, Dr M and Dr S received again the same expression of wish. Dr M was, as Dr S no doubt had been before, at pains to satisfy himself that there was no question of AK being affected by any drugs at the time he gave his expression of wishes, that there was no question of coercion or pressure exerted upon him or felt by him and, although formal tests in the circumstances of AK's condition were impossible, that there was no sign that he was suffering from the kind of depression which might vitiate his consent. Dr M satisfied himself that AK had a clear understanding of what was involved and that what was involved was his death. He also satisfied himself that AK had had explained to him the possible future discovery of the kind of preventive treatment to which I have already referred together with its limitations."

Best interests

Any act done or decision made on behalf of someone who lacks capacity must be in their best interests. Section 4 provides that, when deciding what is in their best interests, the person making the decision must consider:

- whether they are likely to have capacity in relation to the matter in question in the future;
- the need to permit and encourage them to participate, or to improve their ability to participate in the decision-making process;
- their past and present wishes and feelings (and, in particular, any relevant written statement they made when they had capacity), the beliefs and values that would be likely to influence their decision, and any other factors they would consider if they were able to do so;
- if it is practicable and appropriate to consult them, the views of others, such as family members, carers, and anyone else who has an interest in their welfare; and
- whether the purpose for which any act or decision is needed can be as effectively achieved in a manner less restrictive of their freedom of action.

General defence in civil and criminal law

Sections 5 to 8 were originally described by the Law Commission as a “general authority to act”, which has been described by Peter Bartlett as “the least formalistic and most innovative of the legal devices in the Mental Capacity Act.” The essential thrust of the provision is that people who care for people without capacity should be protected from liability for so doing, provided that such care is in the best interests of P and is performed without negligence.

Lasting powers of attorney

Sections 9 to14 create a new statutory form of power of attorney, the “lasting power of attorney” (LPA), which will replace the “enduring power of attorney” (EPA). The main difference between the two types of power is that LPAs can extend to personal welfare matters, as well as the donor’s property and financial affairs, but the donee only has the authority to make a personal welfare decision that the donor is incapable of making at the time.

The Enduring Powers of Attorney Act 1985 will be repealed when the new Act comes into force, but the legal effect of EPAs already made under the current legislation is preserved and integrated into the new scheme by section 66(3) and Schedule 4 of the Act.

Schedule 1 governs the creation, registration, and cancellation of LPAs. A lasting power of attorney must be in the prescribed form, which has yet to be designed but will contain prescribed explanatory information similar to that in the existing EPA legislation. The instrument must also contain a certificate in a prescribed form, signed by a person of a “prescribed description”, that the donor understands the purpose of the instrument and the scope of the authority conferred under it.

Another major difference is that, unlike an EPA, which can come into operation as soon as it is executed, an LPA cannot be used until the Public Guardian has registered it. An application to register an LPA can be made by either the donor or the donee(s). There will be a prescribed form of application and, of course, a fee. The applicant must notify any persons named by the donor as being entitled to receive notice of an application to register the power. There will no longer be any duty to notify relatives in accordance with a statutory order of priority. The Public Guardian must notify the donor and the donee(s) (a) when the application is received and (b) when the instrument is registered. The Public Guardian must not register the instrument if there is an objection to registration on a prescribed ground.

Court-appointed deputies

Where a person, who has not made an LPA, lacks the capacity to make a decision about his personal welfare or property and affairs, the court will be able to appoint a "deputy" to make that decision for him. There is a widespread misunderstanding that deputies will simply be receivers with a new name. This is not the case, and the Act provides that, when deciding whether it is in a person's best interests to appoint a deputy, the court should have regard to the principles that

- a decision by the court is to be preferred to the appointment of a deputy to make a decision, and
- the powers conferred on a deputy should be as limited in scope and duration as is reasonably practicable in the circumstances: s 16(4).

Although the new Act repeals Part VII of the Mental Health Act 1983, Schedule 5 makes transitional provisions for existing receiverships.

Advance decisions to refuse treatment

Sections 24 to 26 provide a statutory framework, with various safeguards, whereby people can make an advance decision (or "living will") to refuse treatment if they lose capacity in future. An advance decision will have no application to any treatment that a health care provider considers necessary to sustain life unless certain formalities have been complied with. These are that the advance decision must

- be written,
- be signed and witnessed, and
- include an express statement that the decision is to apply "even if life is at risk" (s 25(5)).

Independent mental capacity advocates

Sections 35 to 41, which were a last minute amendment to the draft legislation, deal with the appointment and functions of independent mental capacity advocates (IMCAs), who will represent the views of people, who have no family or friends to support them, and who lack the capacity to consent to the proposals where:

- the National Health Service is proposing to provide serious medical treatment (s 37(1);
- the person is being placed in, or arrangements are being made for a change in, NHS accommodation (s 38), or accommodation provided by a local authority (s 39).

There is some concern about the lack of clarity in the role of IMCAs: why the advocacy service should be limited to these circumstances; what "serious medical treatment" actually means; how the IMCA service will be organised, and how existing advocacy organisations could be involved in providing the service. The Department of Health has done a consultation on the IMCA service. For further details see: http://www.dh.gov.uk/Consultations/ClosedConsultations/ClosedConsultationsArticle/fs/en?CONTENT_ID=4119900&chk=N4MvII

Codes of practice

Guidance on the Act will be provided in one or more Codes of Practice (sections 43 and 43). The following people have a duty to follow this guidance, and any failure to do so would be considered by the courts in any relevant legal proceedings:

- donees of an LPA
- deputies appointed by the court
- persons carrying out intrusive research as part of an approved research project
- as an IMCA
- in a professional capacity
- for remuneration.

Although this legal duty does not apply to relatives and unpaid carers, they would nevertheless be expected to follow the code as a matter of good practice.

Court of Protection

Section 45 abolishes the existing Court of Protection, and replaces it with a new court, also to be known as the Court of Protection, which will be able to deal with all areas of decision-making for people who lack capacity. Thus, it will combine the personal welfare and healthcare jurisdiction currently exercised by the Family Division, with the property and financial decision-making jurisdiction of the existing Court of Protection. The new court will be regional, served by a centralised administration office and registry.

Section 46 describes the judges of the new Court of Protection. There will be a President and Vice-President. On 26 September 2005 Sir Mark Potter, the President of the Family Division, was appointed President designate, and Sir Andrew Morritt, the Chancellor of the High Court, was appointed Vice-President designate.
http://www.gnn.gov.uk/environment/detail.asp?ReleaseID=171010&NewsAreaID=2&NavigatedFromDepartment=True

The other judges will be nominated from various levels of the judiciary, through High Court judges from all three divisions, to circuit judges and district judges. It is anticipated that the jurisdiction will be confined, initially at least, to two or three judges per circuit.

The main functions of the new Court of Protection will be to:

- make declarations as to whether or not someone has the capacity to make a particular decision (s 15(1)) .
- make declarations as to the lawfulness or otherwise or any act done, or yet to be done, in relation to a person (s 15(1)(c)).
- make single, one-off orders (s 16(2)(a)); for example, an order authorising the execution of a statutory will, or an order for the sale of a house and the investment of the net proceeds of sale.
- appoint a deputy to make decisions in relation to the matter(s) in which a person lacks the capacity to make a decision (s 16(2)(b)).

- resolve various issues involving LPAs (ss 22 and 23), and EPAs (Schedule 4).
- make a declaration as to whether an advance decision to refuse treatment exists, is valid, or is applicable to a particular treatment (s 26(4)).
- grant permission to persons who are not automatically entitled to make an application to the court (s50).

Office of the Public Guardian

Section 57 provides for the creation of a new, statutory office-holder to be known as the Public Guardian. On 14 November 2005, Richard Brook, currently the chief executive of MIND, was appointed Public Guardian designate. http://www.gnn.gov.uk/environment/detail.asp?ReleaseID=177607&NewsAreaID=2&NavigatedFromDepartment=True

Section 58 confers on the Public Guardian various functions, such as establishing and maintaining registers of LPAs and deputies appointed by the court. At present, the Public Guardianship Office operates as the administrative or executive arm of the Court of Protection, and the two organisations are accommodated in the same building, Archway Tower, 2 Junction Road, London N19 5SZ. However, it is envisaged that, when the new Act comes into force, there will be two distinct organisations, of broadly similar size, in separate offices, and that the court will have an administrative workforce as well as members of the judiciary. This is designed to create a clearer and sharper distinction between the work of the new Court of Protection and the Office of the Public Guardian.

Section 59, which was a last-minute amendment to the legislation, provides for the appointment of the Public Guardian Board, whose duty is to scrutinise and review the way in which the Public Guardian discharges his functions.

Children

The original intention was that the legislation would only involve adults who lack capacity, as does the Adults with Incapacity (Scotland) Act 2000. Section 2(4) of the Act still states that no powers under the Act are to be exercised in relation to a person under 16. However, approximately 70% of the clinical negligence cases the present court deals with result from perinatal injuries, and often the patients are under 16. Accordingly, section 18(3) provides that, as far as property and financial affairs are concerned, the powers under the Act may be exercised even though the person concerned has not reached 16, if the court considers it likely that they will still lack capacity to make decisions in respect of such matters when they reach 18. The converse of this is that the Family Division will retain its jurisdiction to make healthcare decisions on behalf of children. Section 21 provides for the transfer of proceedings to the court best suited to deal with the particular issues involved. So, for example, it may be more appropriate for the Court of Protection to deal with a case involving a seventeen-year-old who lacks capacity, since any order under the Children Act 1989 would expire on the child's eighteenth birthday, at the latest.