

Ethics Toolkit

Mental Capacity Act – England and Wales



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BMA Medical ethics and human rights

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About this toolkit

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

The purpose of this toolkit is to act as a prompt to doctors providing care and treatment for people in England and Wales who lack, or who may lack, the capacity to make decisions on their own behalf. In our view, this is a situation which most doctors are likely to encounter.

The toolkit contains a series of sections relating to specific areas of the Act, such as how to assess capacity, the Act's basic principles, advance refusals of treatment, research, and Lasting Powers of Attorney (LPAs). Although each section refers to separate areas of the Act, there is inevitably a degree of overlap.

This toolkit is not intended to provide definitive guidance on all issues surrounding the Mental Capacity Act. Each section lists additional sources of guidance that should be used in conjunction with this toolkit. In cases of doubt, legal advice should be sought. The toolkit is designed to raise doctors' awareness of the Act, and to provide an aid for good decision making. This toolkit applies to England and Wales. The BMA has separate guidance on decision making for patients who lack capacity in Scotland and Northern Ireland.

The toolkit is available on the BMA's website and individual Trusts, Health Boards, medical schools, and individual healthcare professionals may download it and make copies. We welcome feedback on its usefulness. If you have any comments, please address them to:

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Introduction

The Mental Capacity Act 2005 (MCA) provides a legal framework for decision making on behalf of adults aged 16 and over who lack capacity to make decisions on their own behalf.

The Act applies to decisions taken on behalf of people who permanently or temporarily lack capacity to make such decisions themselves, including decisions relating to medical treatment. All doctors working with adults who lack, or who may lack, capacity must be familiar with both its underlying principles and its basic provisions.

Under the MCA, an action or intervention will be lawful (that is, healthcare professionals will enjoy protection from liability) where the decision maker has a reasonable belief that the individual lacks capacity to consent to what is proposed, and the action or decision is in their best interests. In relation to medical treatment, it is applicable not only to an episode of treatment, but also to those necessary ancillary procedures such as conveying a person to hospital.

There are limits to these powers. A valid and applicable advance decision to refuse treatment, or a valid decision by an attorney or a court-appointed deputy, would take precedence. The MCA also sets limits on the extent to which the freedom of movement of an adult who lacks capacity can be restricted. An adult who lacks capacity can only be restrained where there is a reasonable belief that it is necessary to protect them from harm and the proposed action is proportionate to the risk; where any restriction amounts to a deprivation of liberty, it is only lawful when the appropriate authorisation is in place.

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



Key resources

BMA – [Treating 16 and 17-year-olds in England, Wales, and Northern Ireland toolkit](#)

Care Quality Commission – [About the Mental Capacity Act](#)

Department for Constitutional Affairs – [Mental Capacity Act 2005 Code of Practice](#)

[Mental Capacity Act 2005](#)

Social Care Institute for Excellence – [Mental Capacity Act \(MCA\) guidance](#)



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Capacity and incapacity

What is capacity?

Decision-making capacity refers to the everyday ability we possess to make decisions or to take actions that influence our lives, from simple decisions about what to have for breakfast, to complex decisions about serious medical treatment. In a legal context it refers to a person's ability to do something, including making a decision, which may have legal consequences for themselves or for other people.

When does a person lack capacity?

For the purpose of the MCA, a person lacks capacity if, at the time the decision needs to be made, they are unable to make or communicate the decision because of an 'impairment of, or a disturbance in the functioning of, the mind or brain'. This could be the result of a variety of factors, including mental illness, learning disability, dementia, brain damage, or intoxication. The inability to make the decision, however, *must* be a result of that impairment or disturbance (this is sometimes referred to as the 'causative nexus').

The Supreme Court has confirmed that the correct way to apply the test (which differs to the way it is set out in the MCA code of practice) is as follows:

1. Is the person able to make the decision in question at the time it needs to be made?

If they cannot:

2. Is there an impairment or disturbance in the functioning of the person's mind or brain?

If so:

3. Is the person's inability to make the decision *because of* the identified impairment or disturbance?

The assessment of capacity is 'task specific'. It focusses on the specific decision that needs to be made at the specific time the decision is required. It does not matter if the incapacity is temporary, or the person retains the capacity to make other decisions, or if the person's capacity fluctuates.



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Basic principles

What are the Act's basic principles?

The MCA sets out several principles that govern decisions made and actions taken under its authority. Where confusion arises about how the Act should be implemented, it can be extremely helpful to refer to them.

Actions or decisions that clearly conflict with these principles are unlikely to be lawful, although there may be occasions where they are in tension, and some balancing will be required. A list of the principles, with brief descriptions, is given below.

A presumption of capacity

It is a fundamental principle of English law that adults have the right to make decisions on their own behalf and are assumed to have the capacity to do so. This means that it is never for an adult to prove their own capacity. Where a person intends to take steps on the basis that the adult lacks capacity to make the relevant decision, that person must be able to explain why they consider that they are allowed to do so, including why the adult can be said to lack capacity.

Maximising decision-making capacity

Closely linked to the presumption of capacity, this principle requires that everything practicable must be done to support an individual to make their own decisions before it is decided that they lack capacity to make the decision(s) in question. For example, advocates and communication support might be necessary, and consideration given to whether an individual's decision-making abilities are affected by the time of day or medication regimes. The aim is to ensure that individuals who can make decisions for themselves but may, nevertheless, need some support, are not inappropriately assessed as lacking capacity – see section 6 on supported decision making.

The freedom to make unwise decisions

The fact that an individual makes a rash, unwise or irrational decision, or acts out of character, is not in and of itself proof of incapacity. All adults retain the right to make decisions which seem unwise or irrational to others. Although such actions may raise questions about capacity – where for example they follow a period of illness or an accident – they are not determinative of capacity. What matters is the ability to make the decision, not the content of the decision per se. This means that while an unwise decision might be a reason to consider whether the person has capacity, it cannot be the basis on which they are found to lack capacity.

Best interests

At the heart of the Act lies the principle that where individuals lack capacity, any decision or action taken on their behalf must be in their best interests. Practically speaking, what constitutes an individual's best interests will depend upon the circumstances. Particular attention must be given to statements of current or prior wishes or feelings expressed or made by the individual, and to what is known about the individual's beliefs and values. Further information about best interests can be found in section 5. The BMA also has a separate toolkit on best interests decision making for adults who lack capacity (see key resources).



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The less-restrictive alternative

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



Key resources

BMA – [Best Interests decision-making for adults who lack capacity](#)



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Assessing capacity

Who should assess capacity?

The MCA does not specify who should assess capacity when a patient's ability to make a decision has been called into question. However, anyone who wishes to carry out an action in connection with the care or treatment of an individual, or who wishes to make a decision on their behalf, must have a reasonable belief that they lack the requisite capacity. In its guidance on *Decision making and consent* at paragraph 82 the GMC states:

'Assessing capacity is a core clinical skill and doesn't necessarily require specialist input (e.g. by a psychiatrist). You should be able to draw reasonable conclusions about your patient's capacity during your dialogue with them. You should be alert to signs that patients may lack capacity and must give them all reasonable help and support to make a decision.'

If you believe that the patient may lack the capacity to make a specific decision, then you must assess their capacity to make the decision in question, as set out below. Where consent to medical treatment is required, the healthcare professional proposing the treatment is responsible for ensuring that the patient has the capacity to consent before proceeding.

The reasons why capacity is in doubt should be recorded in the medical record, as should details of the assessment process and its findings. The more serious the decision, the more formal the assessment of capacity is likely to be.

If there is doubt about whether the patient lacks capacity to make a specific decision, it can be helpful to seek support from someone who knows the patient well, for example, another member of the healthcare team or someone close to the patient. Although assessing capacity is a core clinical skill, in complex cases, where you remain unclear as to whether the patient has the requisite capacity, you should seek specialist input from colleagues such as psychiatrists or psychologists. You should also seek specialist input if the patient or someone close to them disagrees with your judgement.

How do you assess capacity?

When assessing an individual's capacity to make a specific treatment decision, doctors should ensure, as far as possible, that any factors likely to affect the patient's ability to decide for themselves are addressed beforehand. These may include medication, medical condition, pain, time of day, fatigue, or mood. Any information must be given as clearly and plainly as possible with communication aids used where appropriate. Those assessing a patient's capacity are also under an obligation to enhance their capacity as far as reasonably possible. This will involve seeking to ensure that patients are engaged in decision making when they are best able to participate and are encouraged to participate in decision making to the greatest extent they are able.

The MCA makes use of a 'functional' test of capacity, adapted from the common law, which focusses on the decision-making process itself.

There are three elements to the assessment of capacity:

1. an inability to make a decision (the functional test);
2. an impairment of, or a disturbance in the functioning of the mind or brain (the impairment/disturbance test); and
3. a causal link between the two (in other words, the inability to make a decision must be caused by the impairment).



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Under the functional test, a person is regarded as being unable to make a decision if, at the time the decision needs to be made, they are unable, even with all practicable support:

- to understand the information relevant to the decision;
- to retain the information relevant to the decision;
- to use or weigh the information; or
- to communicate the decision (by any means).

Where an individual fails one or more parts of this test, they do not have the relevant capacity. Difficult judgements will still need to be made, particularly where capacity fluctuates; where some capacity is demonstrable but its extent is uncertain; or where the impairment – which does not require a formal diagnosis – may interact with coercion or duress from those close to the individual.

If the impairment which is causing the inability to make a decision is temporary and the decision can reasonably be put off until such time as the individual is likely to regain capacity, then it should be deferred. While it is clear that an unconscious patient will lack capacity, most other patients will retain some decision-making capacity, however slight.

A person should not be assessed as lacking capacity until all reasonable steps have been taken to assist them to make the decision and an assessment that a person lacks the capacity to make a decision must not be discriminatory. It must not be based simply on:

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

In assessing capacity, consideration should be given, where appropriate, to the views of those close to the individual. Family members and close friends may be able to provide valuable background information, although their views about what they might want for the individual must not be allowed to influence the assessment of capacity.

The MCA requires that any decision that a person lacks capacity must be based on a 'reasonable belief' backed by objective reasons. Where there are disputes about whether a person lacks capacity that cannot be resolved using more informal methods, the Court of Protection can be asked for a ruling.

More detailed advice on assessing capacity is available from other sources (see key resources).

What do you do when an individual refuses to be assessed?

Occasionally, an individual whose capacity is in doubt may refuse to be assessed. In most cases, a sensitive explanation of the potential consequences of such a refusal, such as the possibility that any decision they may make will be challenged later, will be sufficient for them to agree. However, if the individual flatly refuses, in most cases no one can be required to undergo an assessment. In these circumstances, doctors should document the refusal in the medical record, make a decision about capacity based on the information they have available, and document the decision reached and the reasons for it; where the question of capacity cannot be resolved on the basis of existing information, legal advice should be sought.



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If there are reasonable grounds to believe that the refusal of assessment results from coercion by a third party, legal advice should be sought with a view to approaching the courts.

Key resources

BMA and The Law Society – [Assessment of Mental Capacity \(5th edition\)](#)

BMA – [Best interests decision making for adults who lack capacity](#)

Capacity Guide – [Guidance for clinicians and social care professionals on the assessment of capacity](#)

GMC – [Decision making and consent](#)



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Best interests

What does the Act mean by best interests?

All decisions taken on behalf of someone who lacks capacity must be taken in their best interests. The Act provides a checklist of common factors that must be considered when making a best interests judgement. Case law has established that when assessing an individual's best interests, decision makers must look at their welfare in the broadest sense. This must extend beyond medical factors to incorporate social and psychological dimensions of wellbeing.

As part of the assessment process the Supreme Court has made clear that the decision maker must make a reasonable effort to put themselves in the place of the patient and ask what their attitude to the proposed treatment would be (see also section 6 on supported decision making).

What should you consider when assessing best interests?

Lacking capacity to make a decision should not exclude an individual from participating in the decision-making process as far as possible. The decision maker must also consider whether the person will regain capacity. A decision should be delayed if it can reasonably be left until they regain the capacity to make it.

When determining best interests, assumptions must not be made merely on the basis of the individual's age or appearance, their medical condition, or any aspect of their behaviour – this is the principle of equal consideration and non-discrimination.

In most circumstances it will be clear where the individual's best interests lie, and a decision as to care or treatment will not be challenging or time-consuming – but this is not always the case. Whether to provide analgesics for someone in pain is likely to be a straightforward question; a decision about whether to continue providing life-sustaining treatment is less so. Where a decision is likely to have grave consequences for a person it will require greater consideration, wider consultation with those close to the patient, and more detailed documented evidence about the decision reached and the reasons for it.

Relevant factors to consider are likely to include (so far as they are reasonably ascertainable):

- the person's past and present wishes and feelings, including any relevant written statement made when they had capacity;
- the person's wishes, beliefs, or values where they would have an impact on the decision; and
- other factors the person would have considered if able to do so, such as the effect of the decision on other people.

For significant decisions, a crucial part of best interests assessments involves discussion with those close to the individual, including family, friends, or carers, where it is practical or appropriate to do so, bearing in mind the duty of confidentiality (for more on information sharing, see section 18). It should also include anyone previously nominated by the person as someone to be consulted.



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Where an individual appointed to act under a Lasting Power of Attorney (see section 7) or a deputy appointed to make decisions by the Court of Protection (see section 8) has the authority to make the decision, they should be provided with as much information as is necessary for them to make the decision in question.

The BMA has separate guidance on best interests decision making (see key resources).

What about decisions relating to life-sustaining treatment?

Where the decision concerns the provision or withdrawal of life-sustaining treatment (including clinically-assisted nutrition and hydration) the Act makes it clear that the person deciding whether the treatment is in the patient's best interests 'must not be motivated by a desire to bring about the individual's death'.

Are there any exceptions to the best interests principle?

There are two circumstances when the best interests principle will not apply. The first is where someone has previously made an advance decision to refuse medical treatment while they had capacity (see section 10). Where the advance decision is valid and applicable, it should be respected, even if others think the decision is not in their best interests. The second exception relates to the enrolment of adults who lack capacity in certain forms of research (see section 15).



Key resources

BMA – [Best Interests decision making for adults who lack capacity](#)
BMA and Royal College of Physicians – [Clinically-assisted nutrition and hydration \(CANH\) and adults who lack the capacity to consent. Guidance for decision making in England and Wales](#)



6

Supported decision making

What does 'supported decision making' mean?

In 2009, the UK ratified the United Nations Convention on the Rights of People with Disabilities (CRPD). Although not incorporated into UK law, the CRPD has ushered in something of a sea-change regarding the care and treatment of people who may lack capacity to make certain decisions. The focus of the CRPD is on *supported* rather than *substitute* decision making.

The implications of the CRPD are complex and challenging. They may also be in tension with some of the principles of the MCA. In this section we set out ways in which doctors can draw on aspects of the CRPD's supported decision making approach to complement their obligations under the support principle in the MCA (see section 3).

Is there a difference between mental and legal capacity under the CRPD?

Yes. Although mental and legal capacity are treated similarly under the MCA, the CRPD relies on a distinction between mental and legal capacity. Legal capacity refers to the formal ability to hold and exercise rights and duties. Under the CRPD, these are universal and cannot be lost. Mental capacity refers to decision-making skills and abilities and these clearly vary from individual to individual.

What does 'supported decision making' mean under the CRPD?

As interpreted by the UN treaty body responsible for the CRPD, the Convention uses the concept of supported decision making in a particular sense. It requires ensuring that people receive the support they need and want to make and express decisions where this is possible. If it is not possible, decisions must be taken in a way that reflects the person's 'will and preferences.' Where their will and preferences are unclear, it is permissible to act according to a 'best interpretation of will and preferences.' This approach now guides decisions made by the Court of Protection. The key difference is that the focus is increasingly on determining what the individual would want – and consider to be in their best interests – in the circumstances, rather than what others believe objectively to be in their best interests.

What measures can enhance supported decision making?

These measures can include:

- exploring with the person how best they can be supported to make decisions;
- identifying, as far as possible, the wishes and feelings of those unable to make decisions. Such wishes and feelings should be complied with when making best interests decisions unless there are compelling reasons to set them aside;
- ensuring facilities are available in healthcare services where assessments of capacity are frequent to ensure the proper support of those being assessed, including an environment conducive to their maximal involvement in decision making; and
- facilitating, as appropriate, the involvement of those close to the individual to support their decision making.

Who is responsible for ensuring appropriate support?

Under the MCA, the obligation to take appropriate steps to support the person to make a decision falls largely on those responsible for assessing the individual's mental capacity. This will include ensuring a conducive environment and ensuring information is provided in an accessible form.



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Lasting powers of attorney

What is a Lasting Power of Attorney?

The MCA includes provisions enabling capacitous adults to nominate another individual or individuals to make health and welfare decisions on their behalf when they lack the capacity to make those decisions. This power, known as a Lasting Power of Attorney (LPA), allows the individual (the donor) to give authority to someone else (the attorney) to make decisions on the donor's behalf. The donor decides who the attorney should be and how wide ranging the power should be. More than one attorney can be appointed and they may be appointed to make some decisions jointly (together) and some decisions jointly and severally (independently). If the LPA does not specify this, then the attorneys must act jointly.

Is there more than one type of LPA?

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

What effect does a health and welfare LPA have?

The Act allows an individual aged 18 or over who has capacity to appoint an attorney under a health and welfare LPA, to make decisions on their behalf once they lose capacity. For it to be valid it must be in writing – using a specified form – and include:

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

Registered healthcare professionals can be certificate providers and, GPs in particular, may find they are asked by patients to fulfil this role.

How do you register an LPA?

An LPA must be registered with the Office of the Public Guardian (OPG) before it can be used. It does not give the attorney any legal power to make decisions before it is registered (and a health and welfare attorney can never have any power to act where the donor has capacity to make the decisions in question). The OPG maintains a register of LPAs and, where there is doubt as to the existence of an LPA, anyone can apply to search the register. They also have a fast-track checking mechanism that healthcare staff can use.



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What powers does an attorney have under an LPA?

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

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

Where an attorney is acting under a health and welfare LPA and they are making decisions in relation to medical treatment, they must act in the donor's best interests. This means healthcare professionals need, independently, to have their own view as to what is in the best interests of the donor so that they can engage with the attorney on an informed basis. If any doubt or disagreement about what is in the donor's best interests cannot be resolved locally, an application can be made to the Court of Protection.

There may be occasions when an attorney cannot face making particularly serious decisions, such as regarding life-sustaining treatment. In these circumstances, those responsible for providing care and treatment should revert to the best interests decision-making process set out in section 5.

What are the differences between an Enduring Power of Attorney and an LPA?

There is a common misunderstanding among patients and their families (and indeed among some healthcare professionals) that an attorney acting under an Enduring Power of Attorney (EPA) has the same power as an attorney acting under a health and welfare LPA. They do not, and it is frequently necessary for a sensitive conversation to take place to explain that an attorney under an EPA does not have any specific decision-making role in relation to health and welfare decisions.

The fundamental difference between the two is that EPAs cover decisions relating to property and financial affairs only, whereas there are two types of LPA, one to deal with financial affairs and one to deal with personal welfare and medical treatment decisions. Although no new EPAs can be made, any that were made before 1 October 2007, and are registered, remain legally effective. LPAs will eventually replace the existing system of EPA, but there will be a number of years during which the two systems continue to co-exist.



Key resources

[Office of the Public Guardian](#)





Court of Protection and Court-appointed deputies

What is the function of the Court of Protection?

The Court of Protection was established by the MCA to oversee the proper functioning of the legislation. The Court has the power to rule on the validity of LPAs as well as to determine their meaning or effect. It also has the power to make a declaration as to whether an individual has or lacks capacity to make particular decisions, and to rule on cases where there is doubt or dispute as to whether a particular treatment is in the best interests of an adult who lacks capacity. The Court of Protection is also likely to need to approve some specific types of treatment or procedures where additional safeguards are considered necessary (see section 12).

What are Court-appointed deputies?

The Court of Protection can appoint deputies as substitute decision makers where a person either never had, or loses, capacity to make relevant decisions and has not appointed an attorney under an LPA.

Deputies can be appointed to make decisions on health and welfare as well as financial matters. They are likely to be appointed where an ongoing series of decisions is needed to resolve an issue, rather than a single decision of the Court.

In most cases, the deputy is likely to be a family member or someone who knows the patient well. However, the Court may sometimes appoint a deputy who is independent of the family, if, for example, there is a history of serious family dispute or the individual's health and care needs are complex.

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

Deputies should inform the healthcare professional with whom they are dealing that the Court has appointed them as a deputy. Deputies will have been provided with official documentation in relation to their appointment. Healthcare professionals should review the documentation to confirm the extent and scope of the authority given by the Court. Healthcare professionals will need, independently, to have their own view as to what is in the best interests of the individual so that they can engage with the deputy on an informed basis. If any doubt or disagreement about what is in the individual's best interests cannot be resolved locally, an application can be made to the Court of Protection.

What are Court of Protection section 49 reports and what obligations do they entail?

Under section 49 of the MCA, the Court of Protection can order reports from NHS health bodies and local authorities when it is considering any question relating to someone who may lack capacity and the report must deal with 'such matters as the Court may direct.' An order under section 49 of the MCA places an obligation on the NHS body to comply, although it is for the NHS body to determine the appropriate person to complete the report. There is no right to charge a fee for preparing a section 49 report. The BMA has separate guidance on section 49 reports (see key resources).



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Key resources

BMA – [Section 49 guidance](#)



9

Independent Mental Capacity Advocates

What is an Independent Mental Capacity Advocate (IMCA)?

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

When should an IMCA be instructed?

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

- an NHS body is proposing to provide, withhold or stop 'serious medical treatment'; or
- an NHS body or local authority is proposing to arrange accommodation (or a change in accommodation) in a hospital or care home, and the stay in hospital will be more than 28 days, or the stay in the care home more than 8 weeks.

Whilst it is not compulsory, IMCAs may also be instructed in a case review of arrangements for accommodation.

There is no discretionary power to appoint IMCAs in other circumstances. This means there is no power to appoint an IMCA where decisions are being made outside a hospital setting or where a non-NHS body is responsible for the care being provided. Nevertheless, where an adult who lacks capacity has no family members or friends available or willing to be consulted, healthcare professionals should take particular care to identify all relevant evidence about what the patient would wish.

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

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



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What is 'serious medical treatment'?

Serious medical treatment is defined as treatment which involves providing, withdrawing, or withholding treatment where:

- in the case of a single treatment being proposed, there is a fine balance between its benefits to the patient and the burdens and risks it is likely to entail;
- in the case where there is a choice of treatments, a decision as to which one to use is finely balanced; or
- what is proposed would be likely to involve serious consequences for the patient.

Examples of serious medical treatment might include chemotherapy and surgery for cancer, therapeutic sterilisation, major surgery, withholding or stopping clinically-assisted nutrition and hydration, and termination of pregnancy.

What are the powers of an IMCA?

To provide necessary support to an adult who lacks capacity an IMCA will have powers to:

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

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



Key resources

Office of the Public Guardian and Department of Health and Social Care – [Making Decisions – The Independent Mental Capacity Advocates Service](#)

Social Care Institute for Excellence – [Independent Mental Capacity Advocates](#)



10

Advance decisions to refuse treatment

Are advance decisions to refuse treatment legally binding?

The MCA makes clear that somebody who is aged 18 or over and has the necessary mental capacity can refuse specified medical treatment for a time in the future when they may lose the capacity to make the decision. This is known as an advance decision to refuse treatment (ADRT).

The MCA's powers are restricted explicitly to advance decisions to refuse treatment. An advance refusal of treatment is binding if:

- the person making the decision was 18 or older when it was made, and had the necessary mental capacity;
- it specifies, in lay terms if necessary, the specific treatment to be refused and the particular circumstances in which the refusal is to apply;
- the person making the decision has not withdrawn the decision at a time when they had the capacity to do so;
- the person making the decision has not appointed, after the decision was made, an attorney to make the specified decision; and
- the person making the decision has not done anything clearly inconsistent with the decision remaining a fixed decision.

When assessing the validity of an ADRT, it is important to remember the principle of the presumption of capacity. The MCA code of practice makes clear that healthcare professionals should always start from the presumption that a person who has made an advance decision had capacity to make it, unless there are reasonable grounds to doubt the person had the capacity to make the advance decision at the time they made it. In cases of genuine doubt about the existence or validity of an advance decision, doctors can provide treatment that is immediately necessary to stabilise or to prevent a deterioration in the patient's condition until the existence, and the validity and applicability, of the advance decision can be established. If doubts cannot be resolved locally, and time permits, legal advice should be sought about applying to the Court of Protection for a declaration.

Advance requests for future treatment, or statements about matters other than medical treatment, are not legally binding, although they can be a very useful indication of a patient's wishes and feelings when making best interests decisions.

Are there limits to advance decisions to refuse treatment?

Although any written or oral statements of patients' future wishes are clearly a vital part of decision making, there are limits to patients' ability to influence their future care. Nobody can authorise or refuse in advance procedures they could not authorise or refuse contemporaneously. They cannot, for example, insist upon treatment that is not clinically indicated. In the BMA's view, it would also be inappropriate for patients to refuse in advance the provision of all forms of 'basic care' such as hygiene and interventions designed solely for the alleviation of pain or distress. This also includes the offer of oral food and water (but not clinically-assisted nutrition and hydration). An advance decision to refuse treatment cannot be used to give effect to an unlawful act.



10

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

Where a patient is subject to compulsory treatment under mental health legislation, an advance refusal relating to treatment provided for the mental disorder for which compulsory powers have been invoked will not be binding, except in respect of treatment delivered in the community under a Community Treatment Order and in some cases of electro-convulsive treatment (ECT). The courts have, however, established that the treating team should proceed with caution before overriding an advance decision made to refuse medical treatment for mental disorder. This could include, for example, considering whether there are any other treatment options available that are less restrictive. An agreed advance treatment plan for mental health conditions can be helpful and would represent a kind of advance statement, although it would not be binding during periods of compulsion.

Is there a specific format for advance decisions to refuse treatment?

Apart from decisions relating to life-sustaining treatment, discussed below, the MCA does not impose any formal requirements for ADRTs. Both written and oral decisions can be valid, provided they are supported by sufficient evidence of their validity and applicability. It is worth bearing in mind that advance decisions can also be recorded, for example on smart phones, although patients have to take appropriate steps to ensure relevant people are made aware of their existence.

The MCA Code of Practice recommends that any ADRT includes the following:

- full details of the person making the advance decision, including date of birth, home address, and any distinguishing features;
- the name and address of the person's GP and whether they have a copy of the document;
- a statement that the ADRT should be used if the person ever lacks capacity to make treatment decisions;
- a clear statement of the decision, the treatment to be refused, and the circumstances in which the decision will apply;
- the date the document was written (or reviewed);
- the person's signature (or the signature of someone the person has asked to sign on their behalf and in their presence); and
- the signature of the person witnessing the signature, if there is one (or a statement directing somebody to sign on the person's behalf).

Where an advance decision is made verbally, healthcare professionals should make a record in the patient's notes, which should include:

- a note that the decision should apply if the person lacks capacity to make treatment decisions in the future;
- a clear note of the decision, the treatment to be refused, and the circumstances in which the decision will apply;
- details of someone who was present when the oral advance decision was recorded and the role in which they were present (for example, healthcare professional or family member); and
- whether they heard the decision, took part in it, or are just aware that it exists.

Although not a legal requirement, it is recommended that ADRTs are reviewed regularly, particularly where there are any material changes in the individual's condition or treatment options, and at least every five years.



10

Can advance decisions extend to refusing life-sustaining treatment?

Although advance decisions can be oral or in writing, an advance refusal will only apply to life-sustaining treatment where it is in writing, is signed and witnessed, and contains a statement that it is to apply even where life is at risk.

How should advance decisions be stored?

The storage of advance decisions, and the obligation to ensure that relevant healthcare professionals are aware of them, are the responsibility of those who make them. A copy of any written ADRT should be given to the patient's GP for storage in the medical record. A copy of the document should be provided to another healthcare professional involved in the patient's care on request. Where possible, the patient should draw it to the attention of hospital staff before an episode of care. It is good practice for anyone who makes an ADRT to draw it to the attention of anyone who may be called upon to assist in making decisions on their behalf, such as friends, family, or any welfare attorney.



11

Treatment in an emergency

Can emergency treatment be provided to adults who lack the capacity to consent?

In an emergency, where consent cannot be obtained, doctors should provide treatment that is immediately necessary either to preserve life or to prevent a serious deterioration in the patient's condition. The only exception to this is where there is clear evidence of a valid and applicable advance decision to refuse the treatment in question (see section 10). Emergency treatment does not have to be restricted to what is immediately necessary. Applying the principles set out above, to consider the person's capacity and best interests, it can also include steps to prevent deterioration in order to ensure that recovery is an option. Where decisions can reasonably be delayed until such time as the adult is likely to regain capacity, or to permit an assessment of capacity and discussion with those close to the patient, then they should be.

What should you do if, in an emergency, a patient refuses treatment and there is doubt about their capacity?

Doctors should take whatever steps are necessary to prevent deterioration in the patient's condition, and then consider questions of capacity and consent. These steps should also be taken if a welfare attorney, with the relevant authority, refuses to give consent but the doctor in charge judges that treatment would be in the best interests of the patient. Once essential treatment has been given, the procedures for resolving disagreement between doctors and attorneys must be followed (see section 17). Where it is clear that a patient has capacity to refuse treatment, or has a valid and applicable advance decision to refuse treatment, doctors cannot provide the treatment unless authorised under mental health legislation. For more information on advance decisions to refuse treatment, see section 10.



12

Treatment requiring special safeguards

What treatments require special safeguards?

For most day-to-day healthcare decisions, the procedures and principles outlined in this guidance are sufficient. There are some treatments, however, that are generally regarded as being more serious or controversial and require either special safeguards, or in the case of the most complex and difficult decisions, referral to court.

What treatments require an application to the court?

Case law and Court of Protection guidance have made clear that certain categories of cases are ones where legal advice should be sought to determine whether an application to court is required. These are cases where:

- at the end of the decision-making process:
 - the decision is finely balanced;
 - there is a difference of medical opinion;
 - there is a doubt or dispute that cannot be resolved locally (see section 17) about whether a particular treatment will be in a person's best interests; or
 - there is a conflict of interest on the part of those involved in the decision-making process that cannot be appropriately managed;
- a medical procedure or treatment is for the primary purpose of sterilisation;
- the procedure is for the purpose of donation of an organ, bone marrow, stem cells, tissue, or bodily fluid to another person;
- the action proposed involves a procedure for the covert insertion of a contraceptive device or other means of contraception;
- it is proposed that an experimental or innovative treatment be carried out; or
- the case involves a significant ethical question in an untested or controversial area of medicine.

An application to court may be required where the proposed procedure or treatment will require a degree of force to restrain the person concerned and the use of restraint constitutes a deprivation of liberty (see section 14). It is also advisable to seek legal advice where the proposed action involves the use of deception to deliver medical treatment (such as covert medication) to the patient on a regular or long-term basis.



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Is Court approval required for decisions relating to the proposed withholding or withdrawal of clinically-assisted nutrition and hydration (CANH) from patients in a persistent vegetative state or a minimally conscious state?

Case law and Court of Protection guidance have made clear that there is no legal obligation to seek Court approval for these decisions unless, at the end of the best interests assessment:

- the way forward is finely balanced;
- there is a difference of medical opinion;
- there is a lack of agreement to a proposed course of action from those with an interest in the patient's welfare; or
- there is a potential conflict of interest on the part of those involved in the decision-making process which cannot be appropriately managed.

Doctors making decisions about CANH for adults who lack capacity should follow the joint BMA and Royal College of Physicians' (RCP) guidance (see key resources).



Key resources

[Applications relating to medical treatment; guidance authorised by the Honourable Mr Justice Hayden, the Vice-President of the Court of Protection](#)

BMA and RCP – [Clinically-assisted nutrition and hydration \(CANH\) and adults who lack the capacity to consent. Guidance for decision-making in England and Wales](#)



13

Restraint and restrictive measures

What is restraint?

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

What are the types of restraint?

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

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

When is restraint lawful?

Restrictive measures should be a last resort and alternatives to restraint must always be considered. Anybody proposing to use restraint must have objective reasons to justify that it is necessary. They must also be able to show that the patient is likely to suffer harm unless proportionate restraint is used. A proportionate response means using the least intrusive type and the minimum amount of restraint for the smallest amount of time to achieve the objective, in the best interests of the patient lacking capacity. The use of restraint must also be proportionate to the likelihood and seriousness of harm.

If these conditions are met, it is permissible to restrain a patient to provide necessary treatment. It also follows that in such circumstances there would be no liability for assault. The restraint must not amount to a deprivation of liberty and if it is considered necessary to deprive someone of their liberty to protect their interests, special safeguards must be employed. For further information on deprivation of liberty, see section 14.

Restraint is less likely to be required where the MCA principles are followed and there is a genuine understanding of the person's wishes, feelings, beliefs and values.

Further information about the use of restraint can be found in the MCA Code of Practice (see key resources)



Key resources

Department for Constitutional Affairs – [Mental Capacity Act 2005 – Code of Practice](#)



14

Care and treatment amounting to deprivation of liberty – the Deprivation of Liberty Safeguards regime (DoLS)

What is the legal basis for a deprivation of liberty for adults?

The MCA makes clear that people who lack the ability to consent to treatment should be cared for in accordance with the 'less restrictive principle' – see section 3. As outlined in section 13, there will be times when this might involve imposing restrictions on a person's liberty. There will be circumstances however in which appropriate and necessary care or treatment that is in an individual's best interests can only be provided in circumstances that will amount to a 'deprivation of liberty.'

Any such deprivation of liberty will only be lawful if it is authorised, either in accordance with procedures set out in the Deprivation of Liberty Safeguards (DoLS) which were added to the Mental Capacity Act by amendments introduced by the Mental Health Act (MHA) 2007, or by a court order. This section gives a brief outline of relevant factors to consider when assessing whether an individual is, or might be, deprived of liberty and outlines the procedure for seeking authorisation. Although individuals may be deprived of their liberty in a variety of settings, including domestic ones, this section focusses on deprivation of liberty in hospitals and care homes where DoLS apply. If a person is to be deprived of their liberty in another setting, a court order will be required.

This is a complex area of law and practice and where doctors identify individuals who may be, or who may need to be, deprived of their liberty they should refer to local protocols, and/or take legal advice.

What are the key points for healthcare professionals?

The key points are as follows:

- the fact that care or treatment amounts to a deprivation of liberty does not mean that it is inappropriate. It means only that it reaches a certain threshold of restriction such that authorisation is required;
- identifying and authorising a deprivation of liberty should not be a substitute for or impede the delivery of the highest standard of care;
- the focus of decision making must remain the best interests of the patient;
- nothing in the MCA or DoLS is designed to prevent the provision of timely and appropriate medical treatment. In an emergency, treatment must not be delayed for the purpose of identifying whether a deprivation of liberty has taken place or seeking its subsequent authorisation; and
- an authorisation for a deprivation of liberty does not provide legal authority for treatment. Treatment for adults unable to consent must be given on the basis of an assessment of their best interests or in accordance with another legal provision of the MCA.



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When might it be appropriate to deprive a patient of their liberty?

Depriving a patient of liberty may be justifiable if:

- it is in their best interests to protect them from harm;
- it is a proportionate response when compared with the harm faced by the person; and
- there is no less-restrictive alternative.

What are the three components of a deprivation of liberty?

The courts have established that there are three parts to a deprivation of liberty:

- the person is being confined in a restricted space for a non-negligible period (the objective element);
- the person has not validly consented to that confinement (the subjective element); and
- the state is responsible for the confinement (state imputability).

What constitutes a deprivation of liberty?

The concept of 'deprivation of liberty' is not straightforward. The Act does not provide a definition of 'deprivation of liberty', referring instead to the meaning of Article 5 of the European Convention on Human Rights.

The Supreme Court judgment in [Cheshire West](#) in 2014 introduced an 'acid test' for what constitutes a deprivation of liberty for the purposes of Article 5. When considering whether an individual may be deprived of their liberty, healthcare professionals should ask three key questions:

- is the person subject to 'continuous supervision and control'?
- is the person 'free to leave'?
- does the person lack the capacity to consent to their care and treatment in those circumstances?

If the person is under continuous supervision and control (sometimes also identified as 'complete supervision and control') and is not free to leave and lacks the capacity to consent to their care and treatment in those circumstances, then the acid test is met. The individual is therefore deemed to be deprived of liberty under Article 5 and authorisation for the deprivation must be sought.

Following the 2017 case of [R \(Ferreira\) v Inner South London Senior Coroner](#) it has been established that where a patient is being treated for a serious physical condition, is unable to give consent to any consequent loss of liberty, and a loss of liberty arises from the patient's condition, not from any imposed constraints, then that individual will not be deprived of liberty under Article 5 of the European Convention on Human Rights (ECHR), so long as the loss of liberty is due to the need to provide care for them on an urgent basis because of their serious medical condition, is necessary and unavoidable, and results from circumstances beyond the state's control. It follows therefore that no authorisation will be required.

In other words, the starting point is that there is no deprivation of liberty, even if the patient cannot consent to the arrangements, where:

- the patient is so unwell that they are at immediate risk of dying anywhere other than in hospital; and
- the arrangements for delivering treatment to the patient are the same as they would be if the patient were able to agree to them.



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What are continuous (or complete) supervision and control?

When considering whether an individual is subject to 'continuous or complete supervision and control', it can be helpful to ask whether there is a care plan in place that means that those looking after the individual will be aware at any time:

- where the individual is;
- what the individual will be doing; and
- what steps they will take if they cannot establish the above.

What is a non-negligible period of time?

Case law has also established that, for the purposes of Article 5, any deprivation of liberty must be for a 'non-negligible' period of time. There is no definition of a 'non-negligible' period of time, but in general the more intense the measures of restraint and the greater the resistance or resentment of the individual, the shorter will be the period. The courts have regarded as little as forty minutes of intense restraint as amounting to a deprivation of liberty.

In deciding whether a confinement for a short period of time will amount to a deprivation of liberty, the following factors should be considered. The presence of any of these will make it more likely that a deprivation of liberty will be, or is, occurring:

- the use or threat of force or coercion;
- particularly severe or serious forms of restraint; and
- the consequences of the restrictions for the person.

When is someone free to leave?

Whether a person is 'free to leave' will depend on whether they are free to come and go or to decide to live elsewhere or whether they would require permission. If permission is required, it is likely that they are not free to leave and therefore this part of the deprivation of liberty test has been satisfied.

Does the person have capacity to consent to that deprivation of liberty?

In addressing this question, the attention must be on the specific circumstances of the individual's care and treatment. The question must be: does the individual have the capacity to consent to the specified care and treatment in the concrete circumstances that are proposed or in place?

What factors are not relevant to a deprivation of liberty?

The purposes for which care and treatment are being provided are not relevant to whether a person is being deprived of their liberty, nor are the nature of any disabilities they may have. Similarly, a person's compliance or lack of objection are not relevant, nor is the agreement of family or carers, the appropriateness or 'normality' of the treatment or the lack of an alternative safe place for treatment.

How do you authorise a deprivation of liberty?

Where it is identified that an individual may be deprived of liberty in a care home or hospital and lacks the capacity to consent, that deprivation of liberty must be authorised under the Deprivation of Liberty Safeguards (DoLS). To do this the 'managing authority' of the hospital or care home must apply to a 'supervisory body' – usually the local authority where the person lives. There are two types of DoLS authorisation: standard and urgent.



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Standard authorisations

After receiving an application for a standard authorisation, the supervisory body must decide within 21 days whether the person can be deprived of their liberty. If the conditions are met, the supervisory body must authorise the deprivation of liberty and inform the person and managing authority in writing. It can be authorised for up to one year. The person does not have to be deprived of liberty for the period of authorisation. The restrictions should stop as soon as they are no longer necessary.

Urgent authorisations

There will be times when a person may need to be deprived of their liberty before a standard authorisation can be provided. In these situations, the managing authority can itself issue an urgent authorisation which can last up to seven days, with an option to extend it for a further seven days if the supervisory body agrees. When issuing an urgent authorisation, the managing authority must also request a standard authorisation.



Key resources

Department of Health and Social Care – [Notes on deprivation of liberty Supreme Court judgments](#)

Faculty of Intensive Care Medicine – [MIDNIGHT LAW: Deprivation of Liberty In Intensive Care](#)

The Law Society – [Deprivation of Liberty Safeguards: A practical guide](#) (commissioned by the Department of Health and Social Care)



15

Research

Can patients who lack capacity participate in research?

Yes. Under the MCA it is lawful to involve adults who lack capacity in research provided it is related to the condition, or treatment for the condition, from which they are suffering. Research must be approved by an appropriately established research ethics committee, or, in Wales, its equivalent. It must not be possible to conduct the research with individuals who have the capacity to consent. (Different rules apply to participation in clinical trials – see below.)

Where the research is 'therapeutic' and is expected to benefit the individual directly, the risks must not be excessive in relation to the anticipated benefits. Where the research is not expected to deliver direct benefit to the patients but is intended to investigate the condition from which they suffer, the risk to individuals must be negligible and any restriction or intrusion must be kept to a minimum.

Clinical trials under Medicines for Human Use (Clinical Trials) Regulations 2004 are subject to their own rules and regulations and guidance should be sought from professional bodies and health and social care guidance before such trials are carried out. (In April 2014, the EU adopted the Clinical Trials Regulations 2014 to repeal the earlier Directive on which the 2004 Regulations are based. However, it had not become applicable in the EU when the UK exited the EU and will therefore only be incorporated into UK law if specific, domestic steps are taken to bring this about.)

What safeguards exist for individuals who lack capacity?

Before an adult who lacks capacity can be involved in research, the researcher must make reasonable efforts to identify someone who is close to them – although not in a professional capacity – who is willing to be consulted about the appropriateness of their involvement. This will ordinarily be a family member. It could also be a welfare attorney or court-appointed deputy.

The following additional safeguards are provided under the Act once the research has started:

- nothing should be done to adults who lack capacity as part of the research to which they appear to object, unless it is intended to protect them from harm or to reduce or prevent pain or discomfort;
- where individuals who lack capacity show signs of distress or resistance, or indicate by any means the wish not to continue in the research, they must be withdrawn;
- the interests of individuals must outweigh the interests of medical science and society; and
- nothing must be done that is contrary to any advance decision or statement, or prior statement of wishes or preferences – provided those statements or decisions have not subsequently been withdrawn.

Where an adult is withdrawn from research, they may continue to receive any treatment they had received as part of the research where there are good grounds to believe that its withdrawal would pose a significant risk to the individual's health.



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

In December 2006, an amendment to the 2004 Clinical Trials Regulations introduced provisions enabling patients to be enrolled in clinical trials of pharmaceutical products without prior consent in emergency situations where the research is approved by an appropriate research ethics committee. Where research falls outside the Clinical Trials Regulations it would need to be lawful under the terms of the MCA.

Given the potential vulnerability of adults lacking capacity who are enrolled in research, it is important that doctors undertaking such research are familiar with the substantial body of guidance reflecting international standards for research involving patients who lack capacity.

Is there research that does not require the safeguards in the MCA?

Some research does not require the consent of the person subject to the research and can therefore be done without consent and without the safeguards in the MCA. This includes:

- some research including anonymised data (such as statistics);
- research using confidential patient information under the Health Service (Control of Patient Information) Regulations 2002; and
- research with anonymised human tissues under the Human Tissue Act 2004.

Can doctors provide innovative treatment to patients lacking the capacity to consent to it?

Doctors have always modified methods of investigation and treatment in light of experience and so innovative therapy is a standard feature of good care. There are occasions however where innovative treatment may involve exposing patients to significant risk. Where adults lack the capacity to consent to innovative treatment, any such treatment must be governed by the MCA, in particular it must be in the person's best interests. Where any proposed treatment differs significantly from existing practice and involves unknown or significant risk, considerable care must be taken as innovation can give rise to legal and ethical uncertainty. In these circumstances, it is advisable to seek both expert clinical scrutiny and legal advice.



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Relationship with the Mental Health Act

MHA or MCA?

The relationship between the Mental Capacity Act (MCA) and the Mental Health Act (MHA) is a key issue for healthcare professionals. Historically, mental health and mental capacity legislation have had different aims, with the focus of mental health legislation being on managing risk, while capacity legislation has focussed on supportive decision making. In some circumstances healthcare professionals can be uncertain as to which legal framework to use.

The MHA code of practice (see key resources) contains detailed practical guidance on decisions about whether to use the MCA or the MHA.

Where an individual lacks capacity to consent to treatment for mental disorder, and it is reasonable and possible to do so, professionals should generally apply the provisions of MCA, since it is likely to be less restrictive of a person's human rights and freedom of action. However, there may be circumstances when the more formal safeguards provided under mental health legislation, may be more appropriate, including, for example, where:

- it is not possible to give the person the care or treatment they require without doing something that will deprive them of their liberty;
- the person needs treatment that cannot be given under the MCA, such as where the person has made a valid and applicable advance decision to refuse the proposed treatment or part of it;
- the person may need to be restrained in a way that is not permitted under the MCA;
- it is not possible to assess or treat the person safely or effectively without using compulsory powers; or
- the person may lack capacity in some areas but retains the capacity to refuse a vital part of the treatment and has done so.

What is the MCA/MHA interface?

There may be circumstances in which either legal framework may apply and the question as to which Act applies will be for the judgement of the healthcare professional. However, as a rule of thumb if the patient retains capacity the MCA cannot be used. If the treatment is for a physical condition, then the MHA cannot be used. Where detention is deemed necessary, the MHA should be used provided the relevant grounds are met.

Where a patient who lacks capacity has a physical disorder that arises as a 'consequence' of their mental disorder, it is possible that treatment can be provided under either mental capacity or mental health legislation. In relation to the choice as to which legislative framework to use in these circumstances, the BMA recommends that where there is resistance or objection to treatment, either for a mental disorder or for a physical disorder that is a consequence of the mental disorder, mental health legislation should be used. In the absence of resistance or objection from the patient, mental capacity legislation can be used, provided the patient meets the relevant criteria.



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Except in respect of treatment delivered in the community under a Community Treatment Order and some cases of electro-convulsive therapy (ECT), advance decisions relating to compulsory treatment provided under the authority of the MHA are not binding – although the courts have established that the treating team should proceed with caution before overriding such a decision. Where, however, a valid and applicable advance decision exists for treatment not covered by the compulsory powers of the MHA, it is likely to be binding. Similarly, where an adult is subject to compulsory powers, all non-MHA decisions relating to their general care and treatment – for which they lack capacity to consent – will be covered by the MCA.



Key resources

Department of Health – [Code of Practice: Mental Health Act 1983](#)



17

Dispute resolution

When can disputes occur?

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

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

It is clearly in everybody's interests that disagreements are resolved as soon as possible, and with as much consensus as possible. Broadly speaking, disputes can be resolved either informally or formally. Some disputes will be so serious that it may be necessary to make an application to the Court of Protection. This section sets out briefly the different options available for resolving disputes in relation to adults who lack capacity.

How should a dispute be approached initially?

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

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

When should mediation be considered?

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

What if a complaint is made?

It may be that as part of the dispute resolution process, those acting on behalf of an adult who lacks capacity might wish to lodge a complaint about the services they have received. Healthcare professionals should be able to provide information about which complaint procedures would be appropriate in the circumstances. Initially the Patient Advice and Liaison Service (PALS) may be able to deal with the problem informally. PALS does not investigate complaints, but it can, where appropriate, direct people to the formal NHS complaints process.

What role does the Court of Protection have in disputes?

The Court of Protection is the final arbiter in relation to matters arising under the Act. Where disputes have arisen that cannot be resolved in any other way, legal advice should be sought and it may be necessary to make an application to the Court of Protection. Where this is the case, relatives and carers of the patient, and where possible, the patient, should be informed and advised to seek legal representation.



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Going to court can be distressing for those concerned. However, the benefits are that a court can give rulings very quickly when necessary, and it can provide a protective role for both patients and the healthcare team who treat them in cases where there is a disagreement that cannot be resolved.

Key resources

[Apply for a one-off decision from the Court of Protection](#)



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Confidentiality and information sharing

Do healthcare professionals owe a duty of confidentiality to patients who lack capacity?

Yes. Healthcare professionals owe the same duty of confidentiality to all their patients whether or not they lack capacity. Healthcare professionals may therefore usually only disclose information about an adult who lacks capacity where it is in the patient's best interests.

What are the roles of proxy decision makers and IMCAs?

Welfare attorneys and court appointed deputies whose authority extends to medical decisions have the right to give or withhold consent to treatment and so must be involved in treatment decisions, although where emergency treatment is required, this may not always be possible or practicable (see section 11).

Where a patient lacks capacity and has no relatives or friends who can be consulted, the Act requires an Independent Mental Capacity Advocate (IMCA) to be appointed and consulted about all decisions about 'serious medical treatment', or place of residence – see section 9. The healthcare team must provide the attorney, deputy, or IMCA with all relevant information including the risks, benefits, side effects, likelihood of success, and level of anticipated improvement if treatment is to be given, the likely outcome if treatment is withheld and any alternatives that might be considered. While it will therefore be necessary for attorneys, deputies, and IMCAs to have information that will enable them to act or make decisions on behalf of the patient, it does not mean that they will always need to have access to all the patient's records. Only information relevant to the issue in question should be disclosed.

What role do relatives, carers, and friends have?

Where patients lack mental capacity to consent to disclosure it is usually reasonable to assume that they would want people close to them to be given information about their illness, prognosis, and treatment unless there is evidence to the contrary. This does not however mean that all information should be routinely shared. Where the information is particularly sensitive, a judgement will be needed about how much information the patient is likely to want to be shared and with whom. Where there is evidence that the patient did not want information shared, this must be respected.

Those close to a patient who lacks capacity have an important role in decision making whether they have a formal role as a proxy decision maker (attorney or deputy), or more informally in terms of helping the healthcare team to assess the patient's best interests. It may not be possible to carry out these roles without some information being provided about the medical condition of the patient.

Is there a role for 'next of kin'?

Despite the widespread use of the phrase 'next of kin' this is neither defined, nor does it have formal legal status in relation to decision making about medical treatment. A 'next of kin' has no rights of access to a patient's medical records or to information on a patient's medical condition. On the other hand, if, prior to losing capacity, a patient nominates a 'next of kin' and gives authority to discuss their condition with them, they can provide valuable information to the staff looking after the patient.



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There are no rules about who can and cannot be a next of kin. A patient may nominate their spouse, partner, member of their family, or friend. A patient's family cannot argue who should be the next of kin if the patient has not made a nomination as there is no legal status attached to it.

It is important not to confuse the concept of next of kin with the role of 'nearest relative' under the Mental Health Act (MHA). The individual authorised to undertake that role is subject to the statutory rules under the MHA which are wholly distinct from any nomination of next of kin.

What rights of access does the Office of the Public Guardian have?

The MCA gives the Public Guardian a right of access to the health records of patients who lack capacity. The Office of the Public Guardian (OPG), or a Court of Protection visitor acting on the instructions of the OPG, may therefore ask a healthcare professional to see a patient's records while it is investigating the actions of a deputy or attorney. For example, the OPG may want to establish the mental capacity of a patient at a particular time. If healthcare professionals can release this information promptly, it can help ensure these investigations are completed as quickly as possible. If a request from the OPG concerns a patient who has capacity, however, explicit consent for disclosure must be sought from the patient.

When should disclosures be made to protect adults who lack capacity?

In the absence of a legal requirement, where adults lack the capacity to make a decision about whether or not to disclose information relating to harm or abuse, decisions need to be made on their behalf. Healthcare professionals can make a decision based upon an assessment of the individual's best interests. When considering a disclosure of information, any assessment of best interests will ordinarily involve discussion with those close to the individual. However, care must be taken to ensure that anyone consulted who is close to the individual is in fact acting in the person's interests. Healthcare professionals must disclose information to the appropriate authority where there is a belief that an adult lacking capacity is at risk of abuse or other serious harm, unless it is not in the overall best interests of the patient to do so.



Key resources

BMA – [Confidentiality and health records toolkit](#)

BMA – [Best interests decision making for adults who lack capacity toolkit](#)





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