RadcliffesLeBrasseur

Care Homes Briefing

Solicitors

Number 41

Implementing the Mental Capacity Act

The Mental Capacity Act 2005 is not yet in force. However it is expected to come into force in April 2007 and the Government has recently published[1] a new draft Code of Practice which seeks to provide extensive guidance on the implementation of the Act.

Many Healthcare providers have already organised training on the effect of the Act for their staff[2] and have started working on revising their policies to take account of the new Act.

However, there are one or two recurring issues that have already been raised by the consideration of the Act prior to implementation:

Advance Decisions

The Act codifies the previous Common Law regarding advance decisions. However it is apparent that there is a great deal of lax use of terminology and this can be confusing. The Act refers to "advance decisions"[3]. Advance decisions made under the Mental Capacity Act or "advance directives" made under the Common Law, are equally binding refusals of treatment. However, "advance statements" which ask for a specific treatment to be provided are not binding.

There is much confusion about the use of these 3 terms and it is important to look at the underlying nature of the decision to see if it is valid and enforceable.

Interface with the Mental Health Act

By the time the Mental Capacity Act comes into force it is possible that the Government will have enacted the recently announced amendments to the Mental Health Act. These amendments are intended to clarify the interaction between the Mental Health Act and the Mental Capacity Act. However, until those amendments are enacted and in force, the Mental Capacity Act[4] precludes any treatment being given for mental disorder under the terms of the Mental Capacity Act if, when the treatment is proposed, the patient is receiving treatment which is regulated by Part IV of the Mental Health Act[5]

Accordingly, an advance directive/decision refusing treatment for mental disorder will not be binding if the patient is detained and treatment is provided under Part IV of the Mental Health Act. It should however be noted that an advance decision is still applicable to any physical treatment to which it relates.

It should also be noted that Part IV of the Mental Health Act does not apply to patients admitted under Sections 4, 5, 35, 37(4), 135 or 136 and therefore any advance decision is not overridden by Section 28.

[1] March 2006
[2] Training is available from RadcliffesLeBrasseur: please contact andrew.parsons@rlb-law.com
[3] Sections 24-26
[4] Section 28
[5] regulated treatments are treatments provided under Sections 57, 58, 62 and 63 of the Mental Health Act

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Lasting Powers of Attorney and Court Appointed Deputies

For the first time under English Law, the Mental Capacity Act permits an individual to appoint an Attorney to make treatment decisions for them when they have lost capacity (ie to act as a healthcare proxy). The Court may also appoint a Deputy to undertake this function.

A patient who is subject to the Mental Health Act may still appoint an Attorney as long as they have capacity to do so and detention under the Mental Health Act does not affect the validity of any existing LPA or the authority of a previously appointed Deputy. However, Attorneys and Deputies will not be able to prevent treatment under Part IV of the Mental Health Act (which will still be given in accordance with that Act), nor will they be able to decide a place of residence under Guardianship or Supervised Discharge[6]. Attorneys and Deputies, if they have been given this right, will be able to exercise a patient's rights under the Mental Health Act.

Bournewood Gap Patients

In the Bournewood case[7] the European Court held that de facto detention was a breach of Art 5 Human Rights Act, unless detention was in accordance with the Mental Health Act. Where "complete and effective control" of an individual was undertaken, this would amount to a de facto detention.

The Mental Capacity Act does not address the "Bournewood Gap". Accordingly, if it is not possible to provide care for a person who lacks capacity without having to subject them to a level or degree of control which amounts to "complete and effective control" then consideration must be given either to detain the individual under the Mental Health Act or, if it is not clear that an incapacitated individual is subject to the detention criteria, an application to the Court of Protection may be made for guidance as to what is in the best interests of the incapacitated individual.[8] The Mental Capacity Act gives the Court of Protection extended jurisdiction to consider applications to decide questions of best interests.

The recent announced amendments to the Mental Health Act will apparently amend the Mental Capacity Act to clarify this issue and "plug" the Bournewood Gap.

On 29 June 2006 the Government announced its proposals to address this:

- All those involved in the care of individuals lacking capacity must act in their best interests and in the least restrictive manner.
- The detention criteria are to be strengthened.
- The rights of the individual are to be respected and challenges to a decision to detain will be made easier.
- An independent person will be appointed to represent the interests of those without capacity.

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July 2006

[6] see paragraph 12.28 of the Code of Practice.
[7] HL v United Kingdom
[8] see paragraph 5.49 Code of Practice to the Mental Capacity Act

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