The Mental Capacity Act 2005 is not achieving all its original objectives. This article examines the barriers and how these can be overcome.

The Mental Capacity Act 2005 was introduced to protect the rights of people with impaired capacity to make decisions. It is 10 years since the act was passed, and five since the Ministry of Justice (2010) pronounced that “Most health and social care organisations have embraced and delivered the act’s principles and requirements.” However, in some respects, implementation of the act remains unsatisfactory (House of Lords Select Committee on the Mental Capacity Act 2005, 2014). Causes of concern include:

- Presumption of capacity is not always upheld;
- Assessments of capacity are not always carried out correctly, with people being assessed on the wrong criteria;
- The legal framework for proxy decision-making is not always clear.

As a result of these shortcomings, the rights and freedoms of some of the most vulnerable members of society – such as people with learning disabilities, patients left unconscious after serious trauma, and people with mental ill health including those living with dementia – are not always upheld.

In the absence of a definitive evaluation tool, this article explores the findings of HLSCMCA (2014), research in health and social care and legal judgments to consider:

- Why there are persistent gaps in practitioner knowledge;
- The reality of putting theory into practice;
- The impact of risk aversion.

Although the MCA applies to anyone with a cognitive impairment, such as people with mental ill health and those with learning disabilities, this article places specific focus on how the issues raised may affect people living with dementia or those caring for them. While Deprivation of Liberty Safeguards (DoLS) were introduced into the MCA by the Mental Health Act 2007, consideration of these is beyond the scope of this article, which focuses on the MCA as enacted, and makes recommendations that could help transform education and practice.

Why focus on dementia?
Dementia is generally age related, and more common in those aged over 60 years (Jacques and Jackson, 2000). It has been estimated there are currently 800,000 people in the UK living with dementia,

5 key points

1. Implementation of the Mental Capacity Act 2005 has been said to be “patchy” and, in some areas, “poor”
2. There is continuing uncertainty about applying key principles of the MCA
3. Achieving a balance between professional accountability and upholding patients’ rights under the MCA can be challenging
4. Practice cannot be transformed by information giving alone
5. Successful implementation of the MCA may require staff to make cultural and attitudinal changes

The Mental Capacity Act provides a two-stage diagnostic and functional test...
and that prevalence will double over the next three decades (Department of Health, 2012).

As the condition progresses and higher-level cognitive function becomes further impaired, so too does the capacity to make decisions (Jacques and Jackson, 2000). While both the experience and progress of dementia varies, dementia affects the diverse cognitive processes associated with decision-making.

Although people with dementia may, and indeed should, be responsible for decisions relating to the daily conduct of their lives, evidence has shown that the voices of people living with dementia may not always be heard (Taylor 2005).

**Gaps in practitioner knowledge**

Assessing capacity

The MCA provides a two-stage diagnostic and functional test but, in some circumstances, rather than the test being applied in its entirety, practitioners sometimes evaluate capacity on the basis of either diagnosis or function alone – or even on the basis of decision outcomes, or on appearance or behaviour. This is not helped by the fact that, other than a statutory outline, no gold standard test of capacity was introduced.

There has been considerable investment of time and money in training staff in how to use the MCA. Between 2006 and 2008 the Department of Health (2006) made £8.65 million available to councils with social services responsibilities to provide MCA training to local NHS, social services, local authority, and health and social care providers in the local voluntary and independent sector, and commission Independent Mental Capacity Advocacy services.

Although training has been shown to help strengthen practice in areas such as documentation (Wilson et al, 2010), persistent gaps in practitioner knowledge have been demonstrated. Willner et al (2011) found that some staff – albeit a small minority – had not undergone any MCA training yet demonstrated the same level of understanding as those who had, raising some questions about the efficacy of training. Generally, a need for further guidance and training in key areas of the MCA has been identified (Alonzi et al, 2009), even within specialist staff such as learning disability psychiatrists (Sawhney et al, 2009).

So why, given the resources made available, has a need for further training been identified? One possible explanation may be found in the HLSCMCA’s (2014) report, in which the former national implementation manager for the MCA conceded that from 2007, the focus of the implementation programme shifted away from the MCA in general, to the implementation of the DoLS. This shift in focus may have had some impact on the ongoing implementation of the MCA beyond the DoLS as enacted in 2007.

A further possibility is that not all forms of MCA training are fit for purpose. Willner et al (2013) compared the knowledge and understanding of a sample of 80 health and social care practitioners and six clerical workers before and after attending combined lecture and workshop training. They found that after training, participants had a good recall of facts relating to issues such as the presumption of capacity. They also found that the need to avoid inferring incapacity on the basis of an imprudent decision, but understanding of key areas on the application of the MCA was less proficient. For example:

- 44% of participants remained unaware of the two-stage functional and diagnostic test of capacity;
- 66% thought capacity should be considered on the basis of decision outcomes;
- 28% thought mental capacity should be assessed by a specialist practitioner.

Willner et al (2013) suggested that, while conventional training may help staff to identify issues relating to mental capacity, it may not adequately equip them with the skills and knowledge necessary to manage mental capacity issues in practice.

**Best interests principle**

Other evidence indicates that a lack of clear understanding of concepts fundamental to the MCA is not limited to health practitioners. For example, although the principle of best interests is fundamental to any decision made on behalf of a person who lacks capacity, it was not until the case of Aintree University Hospitals NHS Foundation Trust v James (by his litigation friend, the Official Solicitor and others (“Aintree v James”) [2013] that there was clarity – even within the legal profession – as to what “best interests” actually meant.

When this case was heard in the Court of Appeal, an “objective” test of what would be in the best interests of a “reasonable patient” had been applied. As a result, rather than looking at treatment decisions in relation to individual patients and their particular needs and preferences, the Court of Appeal said a more general approach should be taken – ie, what would be in the best interests of a patient in this set of circumstances. When Aintree v James was appealed in the Supreme Court, this method was rejected – instead, it was made clear that any best-interests decision must be:

- Subjective;
- Consider an individual’s preferences on a decision-specific basis.

The decision must be based not only on the individual’s medical welfare, but also take into account potential psychological and social outcomes of the intervention. The person making the decision should, as far as possible: “Put themselves in the place of the individual patient and ask what his attitude to the treatment is or would likely to be” (Aintree v James [2013]).

For an intervention to be in patients’ best interests, it needs only to give them subjective benefit of some kind. Nurses and other decision-makers must make sure they establish patients’ views and attitudes by consulting (as far as possible):

- The patient;
- Those responsible for his or her care;
- Those with an interest in the patient.

**Variable cognitive states**

It is important that practitioners not only understand the key principles of the MCA but are aware of how the legislation applies when a person’s cognitive status is variable, as is the case when people have
Nursing Practice

Discussion

Dementia. They also need to recognise that although individuals may lack capacity to make complex decisions, such as where they would like to live, their ability to make more straightforward decisions such as what to wear, or what they would like to eat, may remain intact.

The evidence suggests staff may not always have the knowledge and understanding necessary to apply complex legislative provisions to people living with dementia, a group with particularly multifaceted needs given the often fluctuating nature of their cognitive impairment (HLSCMCA, 2014; Emmett et al, 2013; Willner et al, 2011). It may be, for example that a person lacks capacity to make a decision at one point of the day – perhaps in the morning before breakfast – but may have the cognitive skills to make a particular decision later on after breakfast and when in a calm and quiet environment.

Nurses caring for people with dementia also need a working understanding of the role of: » Lasting powers of attorney; » Independent mental capacity advocates; » Court-appointed deputies, who may be involved in decisions relating to a person living with dementia when they lack decision making capacity (Taylor, 2014a).

Challenging capacity

Another area of difficulty is ascertaining when the presumption of capacity should be challenged. If nurses are expected to uphold the patient’s right to make apparently unwise decisions, it is not clear at what point may they legitimately undertake an assessment of capacity (HLSCMCA, 2014).

The general rule is that, in terms of day-to-day interventions – such as the administration of medication or assistance with personal care needs – assessments of capacity should be undertaken by the person responsible for helping with a particular intervention (Taylor, 2014a). However, there are no guidelines in the MCA’s Code of Practice (Department for Constitutional Affairs, 2007) to indicate when an assessment should be initiated or when formal assessment of capacity to make more complex decisions would be necessary (Taylor, 2014a). Evidence suggests that, in practice, assessments tend to be triggered by a patient’s refusal of treatment, as in the fictional case study in Box 1; passive acceptance is less likely to be challenged (HLSCMCA, 2014).

Putting theory into practice

Determinants of behaviour

A number of studies have found that even when practitioners have a general understanding of the principles of the MCA, it does not necessarily follow that they will apply these in practice (Brown et al, 2013; Emmett et al, 2013; Wilson et al, 2010). The reasons for this are not clear, although a lack of perceived benefits and workload concerns have been reported (Sawhney et al, 2009).

The link between knowledge and behaviour should be considered. While most people know that overconsumption of highly calorific foods and inadequate exercise are likely (albeit not necessarily) to lead to weight gain, that knowledge does not always appear to be sufficient motivation to deter people from eating too much, or motivate them to engage in physical activities.

Predictors and determinants of behaviour are more complex than simply knowing what should be done; although level of knowledge may have some value in predicting behaviour, this may not always be so, and is likely to vary according to both the type of knowledge and the behaviour under investigation (Ajzen et al, 2011). It has been proposed that behaviour can more reliably be predicted by exploring the attitudes, beliefs and intentions that underpin it – termed the theory of planned behaviour (Ajzen et al, 2011; Fishbein and Ajzen, 2010; Ajzen, 1991).

Much has been written about the influence of personality on behaviour. Although this is only one psychological theory, it does provide a useful indication that mechanisms for transforming poor practice and/or ingraining models of good practice are more complex than simply giving information.

Changing attitudes

Even before the MCA was passed, the importance of cultural and attitudinal change had been identified (House of Lords and House of Commons Joint Committee on the Draft Mental Incapacity Bill, 2003); unfortunately evidence from the HLSCMCA (2014) report and findings from researchers such as Willner et al (2013) suggest this has not always been achieved.

Given the general age demographic of people with dementia, it is important to...
consider the potential impact of ageism on how practitioners view, and work to uphold the right to autonomy of, older patients. Ageism has been described as regarding older adults in a prejudicial manner, and may range from an apparen
tly benign but patronising wish to safe-
guard older adults from actual or potential harm to a more harmful and overt disre-
gard of their needs and rights (Scrutton, 1990). Another form of discriminatory
behaviour can be observed when those in a position of power, such as doctors, nurses
or lawyers, “infantilise” older adults (Cou-
pland and Coupland, 1995), and perceive
them as dependent, lacking capacity to
make decisions, childlike, lacking in
autonomy and in need of protection
(Taylor, 2005).

Such prejudicial – or, at best stereotyp-
ical – views may influence how statutory
rights and obligations are applied. A
review of the impact of ageism on the pro-
visions of social care in the UK indicated
that not only the focus but also the quality
of assessments performed on older people
differed to those performed on younger
adults (Centre for the Policy on Ageing,
2009). In particular, there tended to be a
greater focus on safety and physical needs
in the older group, whereas those assessing
younger adults demonstrated a greater
commitment to facilitating inclusion and
participation. This reinforces suggestions
that assessments may be motivated by a
desire to avoid risk.

It can be seen from reports such as HLS-
CMCA (2014) and the Francis enquiry
Francis, 2013) that some practitioners are,
for various reasons, unable to see beyond
the physical manifestations of age and
dementia to the reality of existence – to
view people with dementia as having expe-
rienced a long life, possibly given birth and
raised a family, earned a living, and experi-
enced the general joys and challenges of
life. Their physical appearance may be frail
but they remain individuals with prefer-
ences and feelings (Taylor, 2011) and the
MCA upholds their right for this to be rec-
ognised. Without this, personhood and
identity may be rebuffed, and the statutory
safeguards set aside.

Risk aversion
Sometimes a dilemma will arise when
patients make decisions that could expose
them to the risk of harm (Box 1). According
to section 1 of the MCA, patients’ capacity
to make decisions should not be deter-
mined on the grounds that their decisions
are considered unwise; this remains the
case even if they present a threat to their
own life, as highlighted in Airedale NHS
Trust v Bland, [1993].

Practitioners may find it difficult to
understand or accept that a patient does
not wish to receive potentially life-saving
treatment and, in situations where the
patient’s thinking does not agree with pro-
fessional opinion, there is a real danger
that this will be considered evidence of
incapacity – as was the case in EM (by his
petition friend the Official Solicitor) v SC
and another (2012). This practice is some-
times referred to as the “protective impera-
tive” (CC v KK and STCC [2013]). This
desire to protect patients may be coupled
with nurses’ awareness of their legal duty
care (Taylor, 2013).

There may be a conflict between:
- Health practitioners’ obligations
  arising from their professional
  accountability and their duty of care
to patients;
- The statutory requirement to balance
  these with a patient’s rights under the
  MCA (Taylor 2014, b; Mullaly et
  al, 2007).

Recommendations
On the basis of this review, a number of
recommendations can be made relating to
both clinical practice and research (Box 2);
if implemented these could help address
some of the issues that hinder effective
implementation of the MCA.

Conclusion
Evidence suggests there is an ongoing lack
of comprehensive understanding of the MCA,
which has an obvious impact on its
use in practice. Furthermore, knowledge
and understanding of the legislation are
not always reliable predictors of practice,
and there is a need to challenge attitudinal
and cultural factors that might act as a bar-
rier to upholding the rights of people with
(or perceived to have) impaired decision-
making capacity. A review of the training
offered and more research on the links
between knowledge and behaviour could
help address the issues raised.

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23