A Pilot Study of the Early Experience of Consultant Psychiatrists in the Implementation of the Mental Capacity Act 2005: Local Policy and Training, Assessment of Capacity and Determination of Best Interests

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Introduction

The Mental Capacity Act 2005 (MCA)[7] was partially implemented in April 2007 and fully implemented in October 2007 in England and Wales (with the exception of the Deprivation of Liberty Safeguards which were implemented in April 2009). The government estimated that up to 2 million adults in England and Wales may have issues concerning their decision-making capacity (henceforth 'capacity'), and these will included 840,000 people with dementia, 145,000 people with severe learning disability, 1.2 million people with mild to moderate learning disability and 120,000 people with severe brain injury[8]. Additionally, the prevalence of schizophrenia, mania and serious depression are 1%, 1% and 5% respectively[8], and some of these individuals may also lack capacity. Moreover, up to 6 million family and unpaid carers are estimated to provide care or treatment for individuals lacking capacity[8]. Furthermore, many other people who do not lack capacity may use aspects of the MCA for future planning.

In an English study of acute admissions to general medical wards, 31% of patients lacked capacity pertaining to their main treatment or investigation, but only a quarter of these were recognised by clinicians to lack capacity[9]. A similar study of psychiatric inpatients revealed 44% of inpatients lacked capacity[10]. An English study of capacity to consent to geriatric psychiatry inpatient admission revealed 48% of the sample lacked this capacity[11]. A recent systematic review concluded that up to 50% of psychiatric inpatients lacked capacity to consent to their admission[12]. Moreover, it is particularly likely to apply to people with severe and enduring mental illnesses, including those with schizophrenia, bipolar affective disorders, dementias and other organic disorders, and people with learning disabilities[11,12]. Therefore, clinicians working in the speciality of psychiatry are likely to have greater experience in the use of MCA.

The MCA has been broadly welcomed by stakeholders and is supported by a Code of Practice[13]. The latter has been developed following extensive consultation and includes case scenarios. Training materials have been developed by the Social Care Institute of Excellence (SCIE) including: core training set; community care and primary care training set; mental health training set; acute hospital training set; and, residential accommodation training set[14]. Nevertheless, there are likely to be a range of difficulties for stakeholders in implementing the MCA. Potential difficulties include: implications for the workload of clinicians and the adequacy of resources to implement the MCA[15,16]; delays in developing training, policy and guidance for a diverse group of clinicians and Independent Mental Capacity Advocates

7 *Department of Constitutional Affairs (2005) The Mental Capacity Act 2005. www.opsi.gov.uk/acts/acts2005/20050009.htm.*

8 *Ministry of Justice (2007) Mental Capacity Act 2005. Equality Impact Assessment. www.justice.gov.uk/docs/mc-equality-impact.pdf*

9 *Raymont V, Bingley W, Buchanan A, David AS et al. (2004) Prevalence of mental incapacity in medical inpatients and associated risk factors: cross-sectional study. Lancet, 364, 1421–1427.*

10 *Cairns R, Maddock C, Buchanan A, David AS, Hayward P et al., (2005) Prevalence and predictors of mental incapacity in psychiatric inpatients. British Journal of Psychiatry, 187, 379–385.*

11 *Mukherjee S, Shah AK (2001) The prevalence and correlates of capacity to consent to a geriatric psychiatry admission. Ageing & Mental Health, 5, 335–339.*

12 *Okai D, Owen G, McGuire H, Singh S, Churchill R, Hotopf M (2007) Mental Capacity in psychiatric patients. Systematic Review. British Journal of Psychiatry, 191, 291–297.*

13 *Department of Constitutional Affairs (2007) Mental Capacity Act Code of Practice (2007 final edition). Code of Practice to the Mental Capacity Act 2005. www.dca.gov.uk/legal-policy/mental-capacity/mca-cp.pdf.*

14 *Stanley N, Lyons C, Manthorpe J, Rapaport J, Rapaport P, Carrhar M, Grimshaw C, Voss S, Spencer L (2007a) Mental Capacity Act 2005 Core Training Set; . (2007b) Mental Capacity Act 2005. Community Care and Primary Care Training Set; (2007c) Mental Capacity Act 2005. Acute Hospital Training Set; (2007d) Mental Capacity Act 2005. Residential Accommodation Training Set; (2007e) Mental Capacity Act 2005 Mental Health Training Set. Department of Health*

15 *Jones R (2005) Review of Mental Capacity Act 2005. Psychiatric Bulletin, 29, 423–427.*

16 *Shickle D (2006) The Mental Capacity Act 2005. Clinical Medicine, 6, 169–173.*

(IMCAs)[15,17]; availability of local training for healthcare and social care professionals[18]; availability of local policies on the implementation of the MCA and their clarity[18]; variable knowledge of the definition of capacity and factors that may trigger an assessment of capacity among healthcare and social care professionals[18]; potential for erroneous perception by carers that capacity is an "all or nothing phenomena" and consequent misuse of the MCA[15]; potential for disagreements between doctors and IMCAs, donees and court appointed deputies[19]; inability of carers to keep written records[15]; and, the potential difficulties with the Deprivation of Liberty Safeguards introduced into the MCA[20,21]. There are also likely to be positive benefits for patients, carers and clinicians.

Therefore, a pilot study to examine the early experience of consultant psychiatrists in the implementation of the MCA was undertaken as part of a larger study to examine several other aspects of the early implementation of the MCA. The particular areas examined in this study included: local policy and training in the application of the MCA, the assessment of decision-making capacity and the determination of best interests.

Methods

This study was undertaken after the MCA had been fully operational for three months in order to ascertain the early experience of consultant psychiatrists in implementing the MCA.

1. Identification of consultant psychiatrists

Consultant psychiatrists working in England and Wales were identified from the Royal College of Psychiatrists' database. Members of the Royal College of Psychiatrists have access to this database and one of the authors (AS) is a member of the Royal College of Psychiatrists.

2. Questionnaire survey of consultant psychiatrists.

All identified consultant psychiatrists working in England and Wales in the specialities of general psychiatry, liaison psychiatry, forensic psychiatry, psychiatry of learning disability and child and adolescent psychiatry were sent an explanatory letter and a specially designed questionnaire in the first week of January 2008 (three months after the full implementation of the MCA); consultant psychiatrists in old age psychiatry were not included because a similar (but separate) study was also being conducted with them from an earlier grant from the Department of Health and SCIE. The questionnaire was anonymous. However, a separate postcard was also sent with the questionnaire. The responding consultant psychiatrist was asked to post the questionnaire and the postcard separately. The postcards allowed identification of consultant psychiatrists who had not been able to respond, whilst maintaining anonymity and confidentiality of the responders' questionnaires. This, in turn, allowed a reminder to be sent to consultant psychiatrists who had not responded within six weeks. One such reminder was sent to those who did not respond.

17 *Cowan J (2007) Are we prepared for the Mental Capacity Act? Clinical Governance: an International Journal, 12, 64–70.*

18 *Myron R, Gillespie S, Swift T, Williamson I. (2008). Whose Decision? An exploration of the preparation for and implementation of the Mental Capacity act in statutory and non statutory services in England and Wales. www.mentalhealth.org.uk/our-work/research/all-age-groups/whose-decision/.Viewed 8th May 2008.*

19 *White SM, Baldwin TJ (2006) The Mental Capacity Act 2005 – implications for anaesthesia and critical care. Anaesthesia, 61, 381–389.*

20 *Khan K, Bhatkal S, Shah AK (2007) Bournewood proposals: practical considerations. Geriatric Medicine. 37, 37–38.*

21 *Shah AK, Heginbotham C, Kinton M. (2008) The newly introduced deprivation of liberty safeguards in England and Wales. Geriatric Medicine, April 2009.*

The questionnaire was designed to examine several aspects of the early implementation of the MCA and is available from the first author. The areas covered in the questionnaire included:

- The availability and utility of local Trust policy on capacity to consent.
- The availability and utility of local Trust policy on the implementation of the MCA.
- The availability and utility of local training in the use of the MCA.
- The documentation of the assessment of capacity.
- The issues for which capacity was routinely assessed.
- The criteria used for the assessment of capacity. This was ascertained by asking the question "What criteria do you use in assessing capacity?", and required a descriptive answer.
- The criteria used in the determination of best interests. This was ascertained by asking the question "What criteria were used to determine best interest?", and required a descriptive answer.
- Identification of professional groups conducting an assessment of capacity.

3. Data analysis

Descriptive answers for the two questions "What criteria do you use in assessing capacity?" and "What criteria were used to determine best interest?" were manually examined and coded by the researchers using a qualitative thematic approach to ascertain common themes. One of the authors (AS) first manually examined and coded the descriptive answers using a qualitative thematic approach, and these were subsequently verified by one of the other authors (NB). Descriptive statistics were used to analyse the categorical responses to all the other questionnaire items pertaining local policy and training in the application of the MCA, the assessment of decision-making capacity and the determination of best interests.

4. Ethical approval

Ethical approval was ascertained from the Faculty of Health Ethics Committee at the University of Central Lancashire.

Results

All identified 955 consultant psychiatrists in the specialities of general psychiatry, forensic psychiatry, liaison psychiatry, learning disability and child psychiatry were sent the study questionnaire; and 865 reminders were sent. One hundred and twenty-six (13%) of these consultant psychiatrists responded and 113 (12%) of these questionnaires were useable as the remaining 13 were blank. Table 1 illustrates the number of questionnaires sent to consultant psychiatrists in each speciality and their response rate. However, the denominator for the number of responses for the examined items from the questionnaire was not 113 because some respondents did not answer these questions.

1. Local policy and training

As illustrated in Table 2, 70% or more of the responding consultant psychiatrists reported that there was a local Trust policy on capacity to consent and that this policy was used, there was a local Trust policy on the implementation of the MCA and that this policy was used, and local training on the application of the MCA, including refresher training and training for new staff, was available. However, less than 50% reported that the training on the MCA was mandatory. As illustrated in Table 3, almost 50% reported that half or more of the staff received training in the application of MCA.

2. Assessment of decision-making capacity

As illustrated in Table 4, over a third of the responding consultant psychiatrists reported that half or more patients had a routine assessment of capacity, and a third reported that half or more patients had the assessment of capacity routinely documented. As illustrated in Table 5, almost two-thirds reported that the capacity was assessed separately for each issue and treatment decision, but about a quarter reported that this was not the case.

Table 6 illustrates the broad issues for which capacity was routinely assessed as reported by the Consultant Psychiatrists. Over two-thirds reported that capacity was routinely assessed for healthcare decisions. About half reported that capacity was routinely assessed for financial welfare. However, less than 50% reported that capacity was routinely assessed for personal care and social care.

The descriptive answer to the question "What criteria do you use in assessing capacity?" were manually coded using qualitative thematic analysis into 15 separate individual categories as listed in Table 7. Around 90% of the responding consultant psychiatrists reported using the four criteria for the specific test of capacity described in the MCA whereby the patient must be able to:

- Understand the information relevant to the decision.
- Retain the information.
- Use or weigh that information as part of the process of making the decision.
- Communicate the decision.

As illustrated in Table 8, over half reported that in at least half the patients having an assessment of capacity both carers and other professionals were consulted.

Table 9 illustrates the proportion of assessments of capacity conducted by different multidisciplinary professionals as reported by consultant psychiatrists. Almost 50% of the responding consultant psychiatrists reported that more than half of the assessments of capacity were conducted by consultant psychiatrists. Almost two-thirds reported that fewer than half of the assessments of capacity were conducted by junior doctors, nurses, psychologists, social workers, occupational therapists and others.

3. Determination of best interests

As illustrated in Table 10, over 90% of the responding consultant psychiatrists reported using the best interests principles for making decisions on behalf of patients lacking capacity.

The descriptive answer to the question "What criteria were used to determine best interest?" were manually coded using qualitative thematic analysis into 14 separate individual categories as listed in Table 11. Over 60% of the responding consultant psychiatrists reported the following five criteria used in the determination of best interests: "involve the patient in the decision-making process", "seek views of carers and relatives", "seek views of carers and relatives about what may have been the patient's views", "consider the views of patients" and "consult other professionals involved in the care of the patient".

Table 12 illustrates the proportion of patients lacking capacity, as reported by consultant psychiatrists, to have had a best interests determination conducted, and had their previous wishes considered, their carers consulted, and advance decisions considered in the determination of best interests. Over 50% reported that over 50% of patients lacking capacity had a determination of best interests. Three-quarters reported that over 50% of patients lacking capacity had their previous wishes considered in the determination of best interests. Almost two-thirds reported that in over 50% of patients lacking capacity their carers were

consulted during the determination of best interests. A third reported that a third of patients lacking capacity had advance decisions considered in the determination of best interests.

Discussion

There may be several explanations for the overall response rate being only 12%. First, it is possible that the Royal College of Psychiatry database may not have been accurate. However, there is no evidence to support this suggestion and the Royal College of Psychiatrists updates this database on an annual basis. Second, Consultant Psychiatrists may have been very busy with many competing priorities at a time when the National Health Service is undergoing many simultaneous changes. Third, the total time interval of 12 weeks given to complete the questionnaire (the initial questionnaire and a reminder sent after six weeks to those who did not respond) may have been too short. Fourth, the questionnaire may have been perceived to be too long and covering too many issues. Fifth, the questionnaire may not have been relevant or less relevant to some psychiatric specialities (e.g. most of the MCA does not apply to those under the age of 16 years and so may have been less important to consultant psychiatrists in child and adolescent psychiatry). Sixth, consultant psychiatrists may have felt that the findings of this study may have little impact in improving the difficulties they may have experienced because the MCA had already been fully implemented (except the Deprivation of Liberty Safeguards added to the MCA, which were implemented in April 2009). Seventh, consultant psychiatrists may have felt that they had insufficient experience to complete the questionnaire because the MCA had only been implemented for three months at the time the questionnaire was first sent out.

Caution should be exercised in extrapolating the findings to other disciplines working in the field of mental health and to specialities other than psychiatry. Caution should also be exercised in the interpretation of findings because of the low response rate. However, the low response rate may be less important in interpreting qualitative data because the absolute number of responses may have been sufficiently large to reach saturation for the qualitative thematic analysis. Moreover, consultant psychiatrists in old age psychiatry were not included in this study because a similar parallel, but separate study, was currently being conducted with them.

Given the early concerns about delays in developing training, policy and guidance for a diverse group of clinicians and IMCAs[15,17,18], it was encouraging that 70% or more of responding consultant psychiatrists reported that there was a local Trust policy on capacity to consent and that this policy was used, there was a local Trust policy on the implementation of the MCA and that this policy was used, and local training on the application of the MCA, including refresher training and training for new staff, was available. Development of local policy and availability of local training on the application of the MCA may have been supported and encouraged by the case scenarios in the Code of Practice accompanying the MCA and the availability of training materials, including those developed by the Social Care Institute of Excellence (SCIE)[14]. The availability of training in the application of the MCA in some Trusts may have been further facilitated by novel approaches whereby local clinicians were trained to train other colleagues in the application of the MCA – for example, the "train the trainer" initiatives used in the West London Mental Health NHS Trust.

Less than 50% of responding consultant psychiatrists reported that the training in the application of the MCA was mandatory. This may explain the observation that only 50% of responding consultant psychiatrists reported that half or more of the staff received training in the application of the MCA. These two observations were of concern because the MCA requires all decision-makers, including healthcare or social care professionals, to follow the principles laid down in the MCA. A study of professionals working

in learning disability reported that professionals requested more training in the application of the MCA[18]. Moreover, there is no statutory requirement for healthcare and social care professionals to undertake formal training in the application of the MCA. Ideally, all healthcare and social care providers should ensure that training in the application of the MCA is readily available to all multidisciplinary staff and that the uptake of this training should be mandatory.

The observation that about a third of responding consultant psychiatrists reported that half or more patients had a routine assessment of capacity and that half or more patients had the assessment of capacity routinely documented may be explained by the first statutory principle of the MCA whereby an individual must be assumed to have capacity unless lack of capacity has been formally established. Thus, capacity may have been presumed in a significant number of patients in the absence of evidence to the contrary. This is supported by the qualitative thematic analysis of the criteria used in the assessment of capacity whereby one of the identified criteria was the presumption of capacity unless there was doubt about capacity. Furthermore, some patients lacking capacity may have been subject to the Mental Health Act 1983 (MHA) and there is no requirement in the MHA to formally assess capacity and document the assessment of capacity other than for treatments covered under Part 4 and 4A of the MHA. The circumstances leading to a formal assessment of capacity for a specific issue require identification in future studies.

The observation that almost two-thirds of responding consultant psychiatrists reported that the capacity was assessed separately for each issue and treatment decision was encouraging given the clear stipulation in the MCA that the assessment of capacity should be for a specific decision and that this assessment should occur at the time the decision needs to be made. However, the observation that about a quarter of responding consultant psychiatrists reported not assessing capacity separately for each issue and treatment decision was of concern. Although the potential for erroneous perception by carers that capacity is an "all or nothing phenomena"[15] has been reported, such concern has not been reported in relation to professionals, including consultant psychiatrists. The precise reasons for capacity not being assessed separately for each issue requires clarification in future studies. Also, formal training for clinicians in the application of the MCA should ensure that clinicians are unequivocally made aware that the assessment of capacity should be decision-specific.

Over two-thirds of responding consultant psychiatrists reported that capacity was routinely assessed for healthcare decisions. This observation, although encouraging, was not surprising because responding consultant psychiatrists are usually involved in making healthcare decisions. The observation that about half of the responding consultant psychiatrists reported that capacity was routinely assessed for financial welfare may reflect a recognition of the vulnerability of psychiatric patients to financial exploitation and mis-management of their finances due to their illness (e.g. patients with bipolar illness manic type may, as part of their illness, spend large sums of money), and that financial affairs of psychiatric patients may have important implications for their long-term management (e.g. funding for placement into a care home is subject to "means" testing by social services). The observation that less than 50% of responding consultant psychiatrists reported that capacity was routinely assessed for personal care and social care was not surprising because capacity on these issues is more likely to be assessed by other professionals including nurses and social workers.

Almost 50% of responding consultant psychiatrists reported that more than half of the assessments of capacity were conducted by consultant psychiatrists. This may be a reflection of the complex circumstances of many psychiatric patients, who may therefore require a senior experienced clinician to assess capacity.

It may also reflect a culture engendered by the requirement under the MHA (prior to its amendment) that capacity should be assessed by the (then) Responsible Medical Officer (usually the Consultant Psychiatrist) in patients whose treatment is subject to Part 4 of the MHA. With the emergence and implementation of "New Ways of Working" increasing numbers of psychiatric patients are initially assessed and subsequently managed by a range of multidisciplinary clinicians[22]. However, the observation that almost two-thirds of responding consultant psychiatrists reported that fewer than half of the assessments of capacity were conducted by junior doctors, nurses, psychologists, social workers, occupational therapists and others was not consistent with the basic philosophy of "New Ways of Working". Collectively these observations suggest that consultant psychiatrists conduct majority of the assessments of capacity despite the MCA clearly stating that the decision-maker for a particular decision should be responsible for the assessment of capacity for that decision. This may, in part, explain the reported increased workload of consultant psychiatrists as result of the implementation of the MCA. The precise reasons for consultant psychiatrists conducting majority of the assessments of capacity and other multidisciplinary clinicians conducting comparatively fewer assessments of capacity requires clarification in future studies.

The reported criterion for the assessment of capacity that there was presumption of capacity unless there was doubt about capacity is consistent with the first statutory principle of the MCA. The reported criteria for the assessment of capacity that capacity should be decision-specific and time-specific are also consistent with the same stipulation in the MCA. The reported criterion that the patient should not be subjected to undue pressure in the assessment of capacity, although not described as a specific criterion for the assessment of capacity in the MCA, is in keeping with the spirit of the MCA and the five statutory principles. The criterion of Gillick competence in the assessment of capacity was reported by a consultant psychiatrists in child and adolescent psychiatry. A child may be Gillick competent to consent to an intervention if s/he has sufficient understanding and intelligence to enable him/her to understand fully what is involved in the proposed intervention.

About 90% of responding consultant psychiatrists reported using the four criteria for the specific test of capacity described in the MCA and listed above in our presentation of results. The criteria described in the MCA for the first stage of the assessment of capacity are:

- Does the individual have an impairment of the mind or brain, or is there some sort of disturbance affecting the way their mind or brain works?
- If so, does the impairment or disturbance mean that the individual is unable to make a decision in question at the time it needs to be made?

Although none of the respondents specifically reported the above two criteria, about 15% of responding consultant psychiatrists reported the presence of cognitive impairment or mental health problems as criteria for the assessment of capacity, and these could be considered in the context of the first stage of the assessment of capacity as described above. It was encouraging that consultant psychiatrists reported using the criteria listed in the preceding paragraphs as they were mostly consistent with those described in the MCA.

A small number of consultant psychiatrists reported the criteria for the assessment of capacity to include "assessment of capacity being in the best interests of the patient" and "seek views of a consultee (e.g. relatives)". These were not consistent with the specific criteria for the assessment of capacity described in the MCA. Moreover, inclusion of these criteria in the assessment of capacity suggests that there may

22 *Department of Health (2005) New ways of working for psychiatrists: enhancing effective, person-centred services through new ways of working in multidisciplinary and multiagency contexts. Final report 'but not the end of story'. www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4122342*

have been confusion between the concept of the assessment of capacity and the concept of the determination of best interests. A small number of consultant psychiatrists also listed age and functional ability as the criteria for the assessment of capacity. These were also not consistent with the criteria for the assessment of capacity described in the MCA. The design of the current study did not allow examination of the reasons for using the four criteria described in this paragraph in the assessment of capacity. The precise reasons for using these four criteria in the assessment of capacity require clarification in future studies. Formal training for clinicians in the application of the MCA should unequivocally clarify the criteria for the assessment of capacity described in the MCA and that the assessment of capacity and the determination of best interests are different (albeit related) concepts.

Over half of the responding consultant psychiatrists reported that in at least half the patients having an assessment of capacity both their carers and other professionals were consulted. This was encouraging because it is important to ensure that the decision for which the assessment of capacity is conducted is the most appropriate decision, and the contribution of carers and other professionals on deciding the appropriateness of a particular decision is important.

It was encouraging that over 90% of responding consultant psychiatrists reported using the best interests principles for making decisions on behalf of patients lacking capacity. Moreover, over 50% of responding consultant psychiatrists reported that over half of the patients lacking capacity had a determination of best interests. The descriptive answer to the question "What criteria were used to determine best interest?" were manually coded using qualitative thematic analysis into 14 separate individual criteria used in the determination of best interests by consultant psychiatrists. It was encouraging that 13 of these 14 criteria were consistent with many of the factors that must be considered in the determination of the best interests as described in the MCA:

- Careful consideration should be given to all circumstances pertaining to the individual lacking capacity.
- Every effort should be made to enable an individual lacking capacity to participate in making the decision.
- Consideration should be given to the possibility that the capacity may be regained (e.g. after treatment of a mental illness) and whether the decision-making can be postponed until the capacity is regained.
- Careful consideration should be given to the past and present wishes and feelings, beliefs and values of an individual lacking capacity. This includes any written statements made when the individual had capacity.
- Careful consideration should be given to the views of other people (close relatives, friends and others who take an interest in the person's welfare) who are close to an individual lacking capacity, anyone engaged in caring for the individual, anyone previously nominated by the individual to be consulted on the decision in question or similar issues, donees of Lasting Power of Attorney or Enduring Power of Attorney, Court-appointed Deputies and Independent Mental Capacity Advocates (IMCAs).
- Special conditions apply to decisions about life sustaining treatment, whereby the decision-maker should not be motivated by a desire to end life.
- There are circumstances when an IMCA must be instructed.
- Careful consideration should also be given to least restrictive alternatives that may be in the best interests of an individual lacking capacity.

Furthermore, it was encouraging that three-quarters of responding consultant psychiatrists reported that over half of the patients lacking capacity had their previous wishes considered in the determination of best interests, and almost two-thirds reported that in over half of the patients lacking capacity, their carers were consulted during the determination of best interests.

A third of responding consultant psychiatrists reported that only a third of patients lacking capacity had advance decisions considered in the determination of best interests. There may be several explanations for this observation in addition to the methodological issues described above. First, consultant psychiatrists may not have had sufficient experience of advance decisions within the first three months of the full implementation of the MCA. Second, psychiatric patients may be less likely to make advance decisions, or may have been less likely to have done so within the first three months of the full implementation of the MCA. Third, consultant psychiatrists may have used the Mental Health Act to over-ride advance decisions. Fourth, this finding may be genuine. The precise reasons for the low rate of consideration of advance decisions in the determination of best interests require clarification in future studies.

It was disappointing that the following factors described in the MCA were not reported to have been considered in the determination of best interests:

- Determination of best interests cannot be based on an individual's age, appearance (including racial appearance or religious dress), condition or behaviour.
- Every effort should be made to enable an individual lacking capacity to participate in making the decision including use of appropriate methods of communication (including professional interpreters) and using other people to facilitate the person to participate in the decision-making process.
- Special conditions apply to decisions about life sustaining treatment, whereby the decision-maker should not be motivated by a desire to end life.

There may be several explanations for these factors not being considered in the determination of best interests in addition to the methodological issues described above. First, the first two factors in the above list may have been assumed to be implicit in the other criteria that consultant psychiatrists reported using in the determination of best interests, and therefore they may not have been specifically described in response to the question designed to ascertain the criteria used in the determination of best interests. Second, consultant psychiatrists are unlikely to have had experience of life sustaining treatment, particularly within the first three months after the implementation of the MCA, because clinicians working in general hospital and primary care settings are much more likely to experience this.

Two consultant psychiatrists in child and adolescent psychiatry reported that the determination of best interests was a parental responsibility. This response was not surprising because most of the MCA does not apply to individuals under the age of 16 years.

Collectively, the above findings suggest that consultant psychiatrists were generally well aware of the criteria for the assessment of capacity and the principles for the determination of best interests described in the MCA and the accompanying Code of Practice.

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Table 1: Response rates of consultant psychiatrists

Speciality	**Number of questionnaires sent**	**Number (%) of responses**
General psychiatry	497	69 (14)
Forensic psychiatry	78	6 (7)
Liaison psychiatry	44	4 (9)
Learning disability	88	11 (13)
Child psychiatry	248	21 (8)
All specialities	**955**	**113 (12)**

Table 2: Local policy and training in the application of the MCA

Item	**Total number of responses**	**Number (%) of "Yes" responses**	**Number (%) of "No" responses**	**Number (%) of "Did not know" responses**
Presence of local Trust policy on capacity to consent	**111**	84 (76)	17 (15)	10 (9)
Local Trust policy on capacity to consent being used	**100**	73 (73)	15 (15)	12 (12)
Presence of local Trust policy on the implementation of the MCA	**106**	76 (72)	16 (15)	14 (13)
Local Trust policy on the implementation of the MCA being used	**93**	65 (70)	14 (15)	14 (15)
Availability of local training on the MCA	**110**	97 (88)	9 (8)	4 (4)
Training on the MCA being mandatory	**104**	49 (47)	43 (41)	12 (11)
Availability of refresher training and training for new staff on the MCA	**102**	72 (69)	17 (16)	13 (13)

Table 3: The proportion of staff who have received training in the application of the MCA

Proportion	**Consultant psychiatrists (%)**
Nil (0%)	2 (2)
Some (1–49%)	22 (23)
Half (50%)	10 (10)
Most (51–99%)	28 (29)
All (100%)	6 (6)
Did not know	29 (30)
Total number of respondents	**97 (100)**

Table 4: Routine assessment of decision-making capacity and the routine documentation of decision-making capacity

Proportion	**Routine assessment of capacity (%)**	**Documentation of the assessment of capacity (%)**
Nil (0%)	5 (5)	6 (7)
Some (1–49%)	25 (27)	29 (32)
Half (50%)	5 (5)	8 (9)
Most (51–99%)	14 (15)	6 (7)
All (100%)	17 (18)	15 (17)
Did not know	27 (29)	26 (29)
Total number of respondents	**93 (100)**	**90 (100)**

Table 5: Assessment of decision-making capacity separately for each issue

	Assessed capacity separately for each issue (%)	**Did not assess capacity separately for each issue (%)**	**Did not know (%)**	**Total number of respondents (%)**
Consultant psychiatrists (%)	59 (61)	24 (25)	13 (13)	**96 (100)**

Table 6: Broad issues for which decision-making capacity is routine assessed

Broad issue for the assessment of capacity	**capacity routinely assessed (%)**	**capacity not routinely assessed (%)**	**Did not know (%)**	**Total number of respondents (%)**
Personal care	32 (36)	41 (47)	15 (17)	**88 (100)**
Health care	69 (73)	13 (14)	13 (14)	**95 (100)**
Social care	39 (45)	33 (38)	15 (17)	**87 (100)**
Financial welfare	49 (54)	28 (31)	14 (15)	**91 (100)**

Table 7: Criteria used by consultant psychiatrists in the assessment of decision-making capacity

Category	**Consultant Psychiatrists (%)**
Presumption of capacity unless doubt about capacity	11 (13)
Cognitive impairment	13 (15)
Mental health problems	14 (17)
Age	2 (2)
Functional ability	1 (1)
Gillick competent	1 (1)
Understanding information	80 (94)
Retaining information	78 (92)
Weighing up in the balance	79 (93)
Communicating the decision	76 (89)
Patient not subjected to undue pressure in the assessment of capacity	7 (8)
Assessment of capacity being in the best interests of the patient	4 (5)
Seek views of a consultee (e.g. relatives)	2 (2)
Assessment of capacity being time-specific	5 (6)
Assessment of capacity being decision-specific	7 (8)
Total number of respondents	**85 (100)**

Table 8: Consultation with carers and other professionals during the assessment of decision-making capacity

Proportion	Consultation with carers (%)	Consultation with other professionals (%)
Nil (0%)	9 (10)	2 (2)
Some (1–49%)	11 (13)	15 (17)
Half (50%)	8 (9)	2 (2)
Most (51–99%)	11 (13)	10 (11)
All (100%)	28 (32)	40 (46)
Did not know	19 (22)	18 (21)
Total number of respondents	**86 (100)**	**88 (100)**

Table 9: The proportion of assessments of decision-making capacity conducted by different professional groups.

Proportion	Consultants (%)	Junior doctors (%)	Nurses (%)	Psychologists (%)	Social workers (%)	Occupational therapists (%)	Others (%)
Nil	3 (5)	21 (36)	24 (43)	29 (54)	31 (59)	35 (57)	35 (66)
Some	9 (15)	21 (36)	13 (23)	9 (17)	7 (13)	3 (6)	3 (6)
Half	6 (10)	1 (2)	2 (4)	0 (0)	1 (2)	1 (2)	0 (0)
Most	14 (23)	1 (2)	2 (4)	2 (4)	1 (2)	1 (2)	0 (0)
All	16 (26)	1 (2)	2 (4)	1 (2)	1 (2)	0 (0)	3 (6)
Did not know	13 (21)	13 (22)	13 (23)	13 (24)	12 (23)	12 (23)	12 (23)
Total number of respondents	**61 (100)**	**58 (100)**	**56 (100)**	**54 (100)**	**53 (100)**	**52 (100)**	**53 (100)**

Table 10: The proportion of consultant psychiatrists using the best interest principles

Proportion	**Consultant Psychiatrists (%)**
Used best interests principles	80 (95)
Did not use best interests principles	2 (2)
Did not know	1 (1)
Total number of respondents	**84 (100)**

Table 11: The criteria used in the determination of best interests

Category	**Consultant Psychiatrists (%)**
Wait until capacity is regained	20 (31)
Involve the patient in the decision-making process	46 (71)
Seek the views of carers and relatives	42 (65)
Seek the views of carers and relatives about what may have been the patient's views	45 (69)
Consider views of the patient	46 (71)
Consider any advance decision	32 (49)
Consult other professionals involved with the patient	43 (66)
Consult donee of Lasting Power of Attorney	37 (57)
Consult Court-appointed Deputy	31 (48)
Consider the advantages and disadvantages of the decision	35 (54)
Consider that the decision was proportionate to the risk	19 (29)
Consider that the decision was the least restrictive option	16 (25)
Referral to an Independent Mental Capacity Advocate	16 (25)
This being a parental responsibility	2 (3)
Total number of respondents	**65 (100)**

Table 12: Consideration of the patient's wishes, advance decisions and consultation with carers in the determination of best interest

Proportion	Patients having determination of best interests (%)	Consideration of patient's previous wishes (%)	Consultation with carers (%)	Consideration of an advance decision (%)
Nil	4(6)	7 (10)	3 (4)	27 (37)
Some	14 (19)	10 (14)	8 (11)	8 (11)
Half	3 (4)	2 (3)	4 (6)	1 (1)
Most	8 (11)	7 (10)	11 (15)	2 (3)
All	30 (42)	31 (43)	33 (45)	21 (29)
Did not know	13 (18)	15 (21)	14 (19)	14 (19)
Total number of respondents	**72 (100)**	**72 (100)**	**73 (100)**	**73 (100)**