



education &amp; training

competencies across specialties for working in niche super-specialised areas. Any such provision needs to be structured to protect the value of the CCT and should have the quality assurance processes of pre-CCT training posts. Post-CCT training should not dilute the increasing importance of continuing professional development within the consultant grade.

## Conclusion

It is clear that there are specialty combinations that remain crucial to service provision and appropriate training must therefore exist to ensure that there are specialists in these areas. However, traditional dual training appears to be under threat and adaptations need to be made to the new structure of postgraduate training to allow trainees to develop the necessary competencies across specialties. The rhetoric surrounding MMC promised greater flexibility of training and it is of paramount importance that this is developed in order for trainees to achieve the broad and diverse range of competencies that are required by these developing services. This will allow us to meet the needs of our patients and deliver the best possible care.

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## Declaration of interest

C.O. is the Chair and O.W. is the immediate past Chair of the Psychiatric Trainees' Committee of the Royal College of Psychiatrists. O.W. is a Specialist Registrar undertaking dual training in Child and Adolescent and Forensic Psychiatry. S.B. is the Registrar of the Royal College of Psychiatrists and a Professor of Child and Adolescent Forensic Mental Health.

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# Mental Capacity Act 2005: views and experiences of learning disability psychiatrists

## AIMS AND METHOD

Postal questionnaires were sent out to 66 learning disability psychiatrists to assess their knowledge and experience of the Mental Capacity Act 2005.

## RESULTS

A response rate of 55% ( $n = 36$ ) was achieved; 22 (61%) respondents felt that patient care had improved; 16 (44%) felt workload had

increased. Despite 79% ( $n = 23$ ) of the respondents feeling that the training for the Act was adequate, only 19% ( $n = 7$ ) were aware of the situations where patients had to be referred to the Independent Mental Capacity Advocate (IMCA) service and only 53% ( $n = 19$ ) were aware that the Act currently does not cover patients who fall in the 'Bournewood gap'.

## CLINICAL IMPLICATIONS

Learning disability psychiatrists are still not conversant with significant parts of the Act and this raises questions about the adequacy of the training delivered. Implementing the Act should improve patient care but will have implications for the workload of professionals.

Mental capacity is the ability of an individual to take decisions that influence an individual's life. Decision-making might vary from simple issues to decide what to eat or wear, to more complex ones about deciding on receiving or refusing medical treatment. It is presumed that by early adulthood every individual gains capacity and this remains throughout life unless demonstrated to be lost permanently such as in people with severe

intellectual disability and dementia, or temporarily as in acute confusional state.

In England and Wales, the Mental Capacity Act 2005 provides a statutory framework for adults (aged 16 years or older) who are unable to make decisions for themselves. The Act has been implemented in a piecemeal fashion. In April 2007, the new Independent Mental Capacity Advocate (IMCA) service became operational in



England only. All other parts of the Act, including IMCAs in Wales, came into force in October 2007. The Code of Practice<sup>1</sup> provides guidance about implementing the Act. Clinicians are legally required to 'have regard to' relevant guidance in the Code of Practice.

Most of the Act confirms and reinforces best practice, and codifies the pre-existing common law provisions. However, there have been significant changes that have been introduced. One of the innovations of the Act is the development of an independent advocacy scheme to support particularly vulnerable incapacitated adults. The Code of Practice has specified that an IMCA must be instructed and consulted for patients who have no one to support them, other than paid staff when serious medical treatment is being proposed or there are proposals to arrange or change accommodation in hospital and/or a care home. An IMCA may be instructed to support someone who lacks capacity when decisions are made regarding care reviews when no one else is available to consult. Irrespective of whether family or friends are involved, IMCAs may be instructed for adult protection cases. The National Health Service or local authorities have a statutory requirement to consult the advocacy services and are deemed to be the 'responsible body' in these circumstances. The Act has introduced two new criminal offences: ill treatment and wilful neglect for violating the statutory recommendations of the Mental Capacity Act.

Protecting the rights of in-patients who lack capacity to consent and adhere to treatment was highlighted in the Bournemouth case (*L v. Bournemouth Community and Mental Health NHS Trust* [1998]).<sup>2</sup> The case concerned a man with autism with severe intellectual disabilities who was informally admitted to Bournemouth Hospital under common law. The European Court of Human Rights in its judgment (*HL v. UK* [2004])<sup>3</sup> found that he had been deprived of his liberty unlawfully without a legal procedure with safeguards and rapid access to a Court of Appeal. The Act makes it clear that it is unlawful under the Act to deprive a person of their liberty within the meaning of Article 5(1) of the European Convention on Human Rights.

The Mental Capacity Act currently does not have the provision to deal with such adherent incapacitated patients. However, the new Mental Health Act 2007 will modify the Mental Capacity Act, which will be used as a vehicle for introducing deprivation of liberty safeguards. The new Mental Health Act 2007 will be implemented from 1 April 2009. In the interim period the Department of Health has issued guidelines for procedural safeguards for protection of this subset of patients.<sup>4</sup>

## Method

We designed a questionnaire consisting of ten questions to ascertain the knowledge and experiences of learning disability psychiatrists about the Act. The questionnaire was anonymous but we asked for basic demographic information on grade and the work place.

Learning disability psychiatrists (consultants, specialist registrars, and staff grades and associate specialists)

working in the region of the Eastern Deanery (Essex, Middlesex, Hertfordshire, Bedfordshire, Cambridgeshire and Norfolk) and in the Ridgeway Partnership Trust (counties of Oxfordshire, Berkshire, Buckinghamshire, Wiltshire and Swindon) were approached. Questionnaires were not sent out to junior trainees as it was felt they would not have enough experience in the specialty to respond to the questionnaire. In total, 66 postal questionnaires were sent out in December 2007.

## Results

Out of 66 questionnaires sent out, 36 were returned, a response rate of 55%. Out of these, 35 respondents identified their grades: 22 consultants, 9 specialist registrars and 4 staff grades and associate specialists. Fifteen of the respondents worked in the Eastern Deanery, 10 in the Ridgeway Partnership Trust and 11 did not specify their place of work. The results from the questionnaires are summarised in Table 1.

## Discussion

In accordance with the guidance issued by the British Medical Association,<sup>5</sup> all doctors working with adults who lack, or who may lack, capacity need to be familiar with the underlying principles and the basic provisions of the Act. Previous surveys indicate that clinicians have limited understanding of the law pertaining to capacity.<sup>6,7</sup> Twenty-nine (81%) doctors in our survey indicated that they had received training about the Act, of which 23 (79%) felt that the training was adequate. Despite this, a startling and rather worrying revelation of our survey was that only seven (19%) respondents were aware of the exact criteria where 'unbefriended' incapacitous individuals must be referred to the IMCA service. This gap in knowledge can potentially have serious legal ramifications, as referral to the IMCA service is a statutory obligation. This also raises the question whether there are other gaps in knowledge in other areas of the Act not explored in this survey.

With the new Act, capacity has to be assessed in relation to a specific decision. This is described as a 'functional' approach as opposed to a 'status' approach where a person having reached a diagnostic threshold would be described as lacking capacity for all decisions. This has major implications, as capacity would need to be assessed in every situation. A study<sup>8</sup> revealed that requests for capacity assessments are mostly reactive (patients refusing management suggested by the clinical team) rather than pro-active. This practice is bound to change with the implementation of the Act. This is expected to increase the workload of professionals as the quantity of capacity assessments would increase. Twenty-eight (78%) of the respondents in our survey revealed that they had been involved in capacity assessments ranging around both physical and mental illness treatment to social issues regarding accommodation changes, finances and other matters since the implementation of the Act. Despite this, surprisingly only



Table 1. Learning disability psychiatrists' experience of the Mental Capacity Act 2005

Questions on Mental Capacity Act 2005	Yes n (%)	No n (%)	Unsure n (%)
1. Did you receive any training for the Act?	29 (81)	7 (19)	
2. If yes, did you feel the training was adequate?	23 (79)	6 (21)	
3. Has the Act changed your practice in any way?	32 (89)	4 (11)	
4. Following the implementation of the Act have you had to assess capacity in any situation?	28 (78)	8 (22)	
5. Do you think your workload has increased since the implementation of the Act?	16 (44)	18 (50)	2 (6)
6. Do you think patient care has improved since the implementation of the Act?	22 (61)	9 (25)	5 (14)
7. Is there an integral process for a referral to the IMCA to be made where you are working?	22 (61)	9 (25)	5 (14)
8. Are you aware of the situation where IMCA has to be involved?	7 (19)	29 (81)	
9. Are you aware of the situations where IMCA might be involved?	8 (22)	28 (78)	
10. Do you think the Act presently covers patients who fall within the Bournemouth gap?	14 (39)	19 (53)	3 (8)

IMCA, Independent Mental Capacity Advocate.

16 (44%) of the doctors felt that their workload had increased.

Improvement in patient care was a positive experience indicated by 61% (21) of the respondents. Some examples of good practice revealed by the respondents were more multidisciplinary involvement, increased IMCA service involvement, greater awareness of legal and ethical issues and improved documentation.

Only 19 (53%) of the respondents in our study were aware of the fact that the Act as it currently stands does not cover patients who lack capacity and adhere to treatment but are admitted informally to in-patient units – the 'Bournemouth gap'. There is limited knowledge about the prevalence of mental capacity among psychiatric in-patients. A study showed that in general hospitals more than 30% of individuals on acute medical wards lack capacity to consent to treatment.<sup>9</sup> A recent study revealed that a third of people admitted to old age psychiatry wards fell into the 'Bournemouth gap'.<sup>10</sup> Another study revealed that 44% of psychiatric in-patients lack treatment-related decisional capacity and out of these 17% fell in the 'Bournemouth gap'.<sup>11</sup> We are currently not aware of any similar study in learning disability psychiatric in-patient units but it is expected that the number of incapacitated patients admitted informally would be higher compared with other specialties.

## Conclusion

The Mental Capacity Act 2005 is in its first year of operation. Given the nature of the patient group learning disability psychiatrists deal with, the expectation will be that they need to be conversant with the basic principles that underpin the Act. Our survey clearly demonstrates that respondents are still unsure about important aspects of the Act, which might have serious legal implications. Although the modest sample size is a limitation of our survey, we have no reason to believe our respondents were an atypical group.

The adequacy of training of professionals in the Mental Capacity Act needs to be more systematically assessed. Training issues regarding various aspects of the

new Act with special emphasis on assessment of capacity and knowledge about the Code of Practice may well need to be implemented in a similar way as it is done for the existing Mental Health Act 1983 (Section 12 Approval).

Clearly the Act provides safeguards for vulnerable people. It empowers people to make decisions for themselves when possible and protects people who lack capacity to do so. However, implementing the Act in day-to-day clinical practice will have implications on the workload of professionals, which needs to be addressed.

## Declaration of interest

None.

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