Mental Capacity Act in Dentistry: A Practical Guide for the Dental Team

Aims: To give an overview of the Mental Capacity Act (2005) (MCA) and the implications for consenting to dental treatment.

Learning Outcomes: On completion of this verifiable CPD article, the participant will be able to demonstrate, through completion of a questionnaire, the ability to:

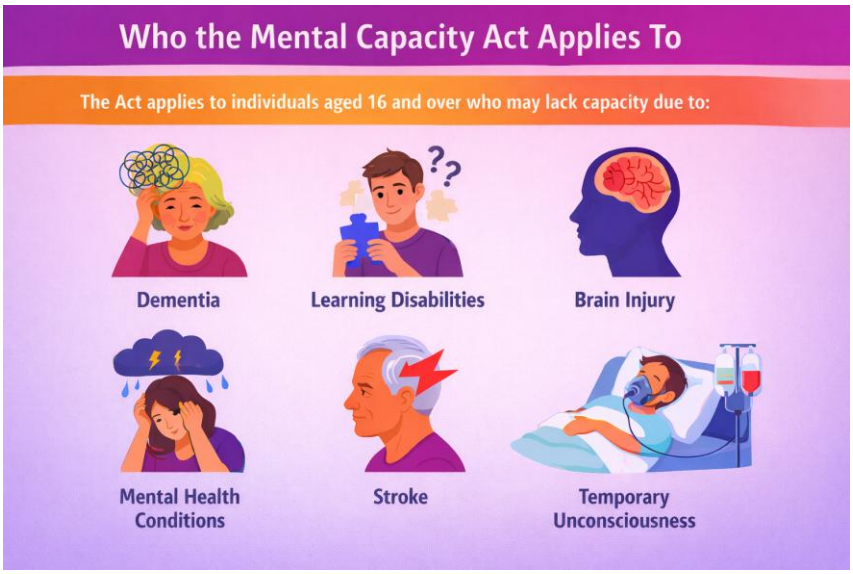
- Demonstrate knowledge of the Mental Capacity Act 2005, The Adults with Incapacity (Scotland) Act 2000, and the Mental Capacity Act (Northern Ireland) 2016.
- Identify who the Mental Capacity Act is designed to protect.
- Explain the five statutory principles of the Mental Capacity Act.
- Apply the two-stage test of capacity.
- Understand CQC Regulation 11: Need for Consent.
- Apply GDC standards relating to consent and capacity.
- Recognise lawful and proportionate use of restraint.
- Identify factors involved in best-interest decision-making.
- Understand Gillick Competence and consent for children.

Introduction

The Mental Capacity Act (2005) came into force in 2007 and applies to individuals aged 16 and over in England and Wales. It provides a legal framework to protect and empower people who may lack capacity to make specific decisions about their care and treatment.[1]

Everyone involved in the care, treatment and support of people aged 16 and over in England and Wales, must comply with the Act when a person lacks the capacity for a particular decision. In Scotland, the relevant legislation is the Adults with Incapacity (Scotland) Act 2000. In Northern Ireland the appropriate legislation is the Mental Capacity Act (Northern Ireland) 2016.

Who the Mental Capacity Act Applies to



The same rules apply whether the decisions are life-changing events or everyday matters.

The Act applies to people aged 16 and over who may lack capacity due to conditions such as:

- Dementia
- Learning disabilities
- Brain injury
- Mental health conditions
- Stroke
- Temporary unconsciousness (e.g. sedation or trauma). [1]

Importantly, a diagnosis alone does not indicate lack of capacity. Capacity must always be assessed in relation to the specific decision at the specific time.[1]

Consent and Capacity in Dentistry

Knowledge and understanding of the Mental Capacity Act (MCA) and the Mental Capacity Act Code of Practice are vital in dentistry if we are to protect our patients' best interests and gain consent for treatment. The law on consent in the UK states that three factors must be met for consent to be valid:

- Consent must be informed.
- Consent must be voluntary.
- Consent must be given by a person with capacity.

Informed Consent

For consent to be informed, patients must be given clear, accurate, and relevant information about their proposed treatment, including the risks, benefits, and alternatives, as well as the option of no treatment. Information should be presented in a way the patient can understand, taking into account their individual needs.

Voluntary Consent

Consent must be given freely, without pressure, manipulation, or coercion. Respecting patient autonomy is fundamental to ethical dental practice. Patients who have capacity also have the right to refuse treatment**,** even if that decision appears unwise.

Capacity to Consent

Assessing capacity is governed by the Mental Capacity Act. Capacity is decision-specific and time-specific; it is not an “all-or-nothing” state. A patient may have the capacity to consent to one procedure, such as a dental examination, but not to another, such as complex restorative or implant treatment.

Capacity may also fluctuate over time. A patient may be able to give valid consent at one appointment but not at another. As a result, consent should be viewed as an ongoing process, and consent documentation and clinical records should reflect this dynamic assessment.[2]

Dental professionals who treat adults who lack capacity, or whose mental capacity may be declining, are legally required to act in accordance with the MCA and its Code of Practice. The Code provides practical guidance on applying the Act in day-to-day practice. Failure to comply with the Act, or to have regard to the Code of Practice, may result in legal liability and may be relied upon in legal proceedings.[3]

The Act aims to support and empower individuals wherever possible, while recognising that some people may be vulnerable and require additional protection.[3]

The Care Quality Commission (CQC)

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

Regulation 11: Need for consent

Regulation 11 requires providers to ensure that people using services, or those lawfully acting on their behalf, have given valid consent before any care or treatment is provided.[4]

The Care Quality Commission (CQC) states that:

“The intention of this regulation is to make sure that all people using the service, and those lawfully acting on their behalf, have given consent before any care or treatment is provided. Providers must make sure that they obtain consent lawfully and that the person who obtains consent has the necessary knowledge and understanding of the care and/or treatment that they are asking consent for.”[4]

The CQC further states that where a person lacks mental capacity to make an informed decision or give consent, staff must act in accordance with the Mental Capacity Act 2005 and its associated Code of Practice.[4]

Between 2023 and 2024, the CQC transitioned from using Key Lines of Enquiry (KLOEs) to a Single Assessment Framework (SAF) to streamline and enhance the evaluation of health and social care services in England.

The SAF replaces the previous KLOEs and prompts with 34 quality statements known as ‘we statements’. These statements define the expected standards of care and are organised under the existing five key questions:

1) Safe
2) Effective
3) Caring
4) Responsive
5) Well-led

To assess compliance with quality statements, the CQC evaluates evidence across six categories:

1) People’s experiences
2) Feedback from staff and leaders
3) Feedback from partners
4) Observation
5) Processes
6) Outcomes

The CQC expect dental staff to have knowledge of the Mental Capacity Act and other relevant legislation and how to apply it to practice.

This is particularly relevant to the Effective question, but also underpins the Safe, Caring, and Well-led domains.

Mental Capacity Act (MCA) within the CQC Single Assessment Framework (SAF)

SAF Domain	MCA Relevance
Safe	Lawful consent, appropriate use of restraint, safeguarding considerations, awareness of DoLS / Liberty Protection Safeguards (LPS).
Effective	Capacity assessments, best-interest decision-making, staff knowledge and application of the Mental Capacity Act.
Caring	Respect for patient autonomy, dignity, involvement in decisions, and person-centred care.
Well-led	Staff training, up-to-date policies, auditing of consent processes, governance and oversight.

The General Dental Council

General Dental Council | protecting patients, regulating the dental team

The GDC Standards for the Dental Team Standard 1 is to "*put patients' interests first*." The GDC state that, as registered dental professionals:

"You must take a holistic and preventative approach to patient care which is appropriate to the individual patient.

1.4.1 A holistic approach means you must take account of patients' overall health, their psychological and social needs, their long-term oral health needs and their desired outcomes.

1.4.2 You must provide patients with treatment that is in their best interests, providing appropriate oral health advice and following clinical guidelines relevant to their situation. You may need to balance their oral health needs with their desired outcomes. If their desired outcome is not achievable or is not in the best interests of their oral health, you must explain the risks, benefits, and likely outcomes to help them to make a decision."

The GDC Standards for the Dental Team Standard 3 is to "*obtain valid consent*". The GDC state that, as registered dental professionals:

3.2 You must make sure that patients (or their representatives) understand the decisions they are being asked to make.

3.2.1 You must provide patients with sufficient information and give them a reasonable amount of time to consider that information in order to make a decision.

3.2.2 You must tailor the way you obtain consent to each patient's needs. You should help them to make informed decisions about their care by giving them information in a format they can easily understand.

3.2.3 When obtaining consent, you should encourage patients who have communication difficulties to have a friend, relative or carer with them to help them ask questions or understand your answers.

3.2.4 You must always consider whether patients are able to make decisions about their care themselves and avoid making assumptions about a patient's ability to give consent.

The General Dental Council acknowledge that this is a complex area, and you should refer to the appropriate legislation. In addition, your defence union can be contacted for advice.[6]

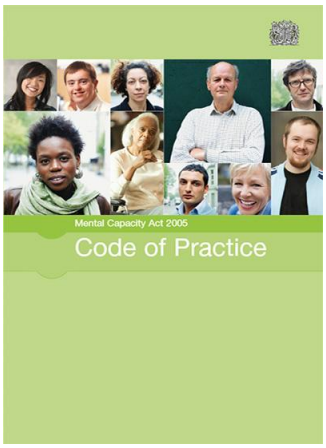
The Five Principles of the Mental Capacity Act

The Act sets out the five 'statutory principles' – the values that underpin the legal requirements in the Act. The Act is intended to be enabling and supportive of people who lack capacity, not restricting or controlling of their lives. It aims to protect people who lack capacity to make particular decisions, but also to maximise their ability to make decisions, or to participate in decision-making, as far as they are able to do so.[7]

- ✓ **Principle 1. A presumption of Capacity** - Every adult has the right to make their own decisions and must be assumed to have capacity to do so unless it is proved otherwise.
- ✓ **Principle 2. Individuals being supported to make their own decisions** - People must be given all appropriate help before anyone concludes that they cannot make their own decisions.
- ✓ **Principle 3. Unwise decisions** - People have the right to make decisions that others might regard as unwise or eccentric and a person cannot be treated as lacking capacity for these reasons.
- ✓ **Principle 4. Best interests** - Any decisions made, or anything done for or on behalf of a person who lacks capacity must be done in their best interests.

- ✓ **Principle 5. Least restrictive alternative** - Anything done for or on behalf of people without capacity should be the least restrictive of their basic rights and freedoms.

Assessing Capacity: The Two-Stage Test



The MCA is supported by practical guidance known as the "Code of Practice". The Code of Practice sets out a two-stage test of capacity:

1) Does the individual concerned have an impairment of, or a disturbance in the functioning of, their mind or brain, whether as a result of a condition, illness, or external factors such as alcohol or drug use?

2) Does the impairment or disturbance mean the individual is unable to make a specific decision when they need to? [7]

The Act states that a person is not able to make a decision in relation to a particular matter if they are unable to:

- Understand the information relevant to the decision.
- Retain the information.
- Use or weigh up the information as part of the process of making the decision.
- Communicate their decision either by using speech, sign language, eye blinking, pointing or any other means including squeezing of hands.

Individuals can lack capacity to make some decisions but have capacity to make others, so it is vital to consider whether the individual lacks capacity to make the specific decision.

Capacity can fluctuate with time - an individual may lack capacity at one point in time but may be able to make the same decision at a later point in time. Where appropriate, individuals should be allowed the time to make a decision themselves.

An example of this would be a patient with dementia who may have more mental clarity early in the day, so appointment times should be tailored to accommodate this factor. Or they may arrive at the practice, and a carer could state that they are having a particularly poor day and, in this case, it may be appropriate to rearrange the appointment.

Dental professionals should also take into consideration how to communicate with the patient. For example, could the information be presented in a different way so that the patient can understand? For example, by using visual aids or other methods of nonverbal communication.

Best Interests – Decisions

If someone is found to lack the capacity to make a decision, and such a decision needs to be made for them, the MCA states the decision must be made in their best interests. People who make decisions for individuals who lack capacity are called “decision makers”.

The MCA sets out a checklist of things to consider when deciding what's in an individual's best interests. It says you should:

- Encourage participation – Do whatever is possible to permit or encourage the person to take part in making the decision. This will involve taking time and tailoring how you give the patient information to the individual’s needs.
- Identify all relevant circumstances – Try to identify the things that are important to the person if they were making the decision themselves.
- Find out the person's views – Including their past and present wishes and feelings, and any beliefs or values. With regard to dental treatment, examine the person’s previous history of dental treatment that they have consented to in the past.
- Avoid discrimination – Do not make assumptions about the person's best interests on the basis of age, appearance, condition or behaviour.
- Assess whether the individual might regain capacity – If they might, could the decision/treatment be postponed? [7]

Consulting with others is a vital part of best-interest decision-making. However, consideration needs to be given to:

- Data Protection Act 2018
- Confidentiality policy
- Human Rights Act 1998
- Equality Act 2010
- Professional codes of conduct

People who should be consulted include anyone previously named by the person concerned, anyone engaged in caring for them, close relatives, friends or others who take an interest in their welfare, any attorney appointed under a Lasting Power of Attorney or Enduring Power of Attorney, and any deputy appointed by the Court of Protection to make decisions for the person.[8]

Always remember that good record keeping is required. This will include details of the two-stage capacity assessment. Why, when, and how best decisions were made and who was involved in the process.

Power of Attorney

A Lasting Power of Attorney (LPA) is a legal document which appoints someone to make decisions on the behalf of someone else. There are two types:

1) **Health and Personal Welfare for England, Scotland, and Wales (called a Welfare Power of Attorney in Scotland)-** Decisions about whether to receive healthcare or stop a healthcare treatment, moving into a nursing home, where to live. This can only be used when the person is unable to make their own decisions at that particular time.

2) **Property and Financial Affairs -** Paying bills, collecting benefits, selling a home. This LPA can be used as soon as it is registered with the person's permission.[7]

A person may have one or both types of LPA. The following factors should be considered:

- ✓ The person must have capacity when they make their LPA.
- ✓ Next of kin and carers do not automatically have decision making authority.
- ✓ LPA cannot override the patient's decision if they are felt to be competent at the point of decision.
- ✓ Even if there is an LPA, always follow the Five Principles of the MCA.

Independent Mental Capacity Advocate

The Mental Capacity Act 2005 introduced the role of the Independent Mental Capacity Advocate (IMCA).

IMCAs are a legal safeguard for people who lack the capacity to make specific important decisions: including making decisions about where they live and about serious medical treatment options. IMCAs are mainly instructed to represent people where there is no one independent of services, such as a family member or friend, who is able to represent the person.[9]

Restraint

It is possible that CQC inspectors may ask dental staff about their Restraint Policy. Dental staff should understand the circumstances in which restraint can and cannot be used. When restraint is used, there should be a process to follow that is safe, lawful and not excessive. The Act requires that the following two conditions are met:

1) The person taking action must reasonably believe that restraint is necessary to prevent harm to the person who lacks capacity.

2) The amount or type of restraint used and the amount of time it lasts must be a proportionate response to the likelihood and seriousness of harm.[7]

Restraint should always be a last resort, clearly documented and consistent with the MCA principles.

Consent for Children

The ability for children under 16 to give valid consent will depend on their maturity and ability to understand what the treatment involves. In England and Wales, this is referred to as being Gillick competent. Other guidelines that exist are 'Fraser guidelines' and these specifically relate only to contraception and sexual health.

To be Gillick competent, a child must:

- Understand the nature of the proposed treatment, its consequences and the alternatives, including no treatment.
- Retain that information.
- Use or weigh up that information in making a decision.
- Communicate that decision.[10]

Parental responsibility

If a child is not Gillick competent, authority to treat or share information may be given by someone with parental responsibility under the Children Act 1989.[11]

Deprivation of Liberty Safeguards (DoLS)

The Deprivation of Liberty Safeguards (DoLS) provide a legal framework to protect individuals aged 18 and over who lack the mental capacity to consent to arrangements for their care or treatment and who are subject to continuous supervision and control, and are not free to leave. DoLS are an amendment to the Mental Capacity Act 2005 and apply in England and Wales.[12]

In dental practice, DoLS are unlikely to apply routinely; however, awareness is important where restrictive measures may be required to deliver care safely to a patient who lacks capacity, particularly where restraint, sedation, or repeated attendance is involved. Dental professionals must be able to recognise when restrictions could amount to a deprivation of liberty and understand the need to escalate concerns appropriately.

Until the Liberty Protection Safeguards are implemented, DoLS remain the lawful framework for authorising deprivation of liberty. The Care Quality Commission expects providers to demonstrate awareness of DoLS and to ensure that any restrictive practices are lawful, proportionate, in the patient's best interests, and in accordance with the Mental Capacity Act and its Code of Practice.[7,11]

Liberty Protection Safeguards

The Liberty Protection Safeguards, introduced by the Mental Capacity (Amendment) Act 2019, are intended to replace Deprivation of Liberty Safeguards (DoLS). As of 2026, LPS have not been implemented, and the existing DoLS framework remains in use.[13]

Practice Considerations

Dental practices should ensure:

- MCA training is included in staff induction and refreshed regularly.
- The practice should have access to the Mental Capacity Act and the Code of Practice.
- Policies reflect current consent and capacity legislation.
- Staff understand the five principles of the Mental Capacity Act and the two-stage test of capacity.
- Capacity assessments are embedded into consent processes.

Conclusion

The Mental Capacity Act provides a vital framework to protect patients who may lack capacity while supporting autonomy wherever possible. Dental professionals must understand the principles of the Act, assess capacity appropriately, and ensure consent is valid, documented, and patient centred.

Regular refresher training supports safe, lawful, and ethical dental care and helps ensure compliance with regulatory and professional standards.

Personal Development Plan and Reflective Learning

This CPD is linked to the following GDC Enhanced CPD Development Outcomes:
A. Effective communication with patients, the dental team and others across dentistry, including when obtaining consent, dealing with complaints, and raising concerns when patients are at risk.
D. Maintenance of skills, behaviours and attitudes which maintain patient confidence in you and the dental profession and put patients' interests first.
Reflective learning is now a requirement of the GDC Enhanced Professional Development Scheme. As such, you will be given the option to answer some reflective learning questions, before your certificate is generated. Please remember you can complete or update this at any time.

Further Reading as appropriate to your area of practice

The Mental Capacity Act Code of Practice is important reading. This code of practice, which has statutory force, provides information and guidance about how the Act should work in practice. It explains the principles behind the Act, defines when someone is incapable of making their own decisions and explains what is meant by acting in someone's best interests. It describes the role of the new Court of Protection and the role of Independent Mental Capacity Advocates and sets out the role of the Public Guardian. It also covers medical treatment and the way disputes can be resolved.

- Mental Capacity Act Code of Practice
- The Mental Capacity Act (2005)
- Adults with Incapacity (Scotland) Act 2000
- The Mental Capacity Act (Northern Ireland) (2016)
- Principle Three of the GDC Standards: Obtain Valid Consent

References

1. NHS (2024) Mental Capacity Act. Available at: https://www.nhs.uk/conditions/social-care-and-support-guide/making-decisions-for-someone-else/mental-capacity-act/ (Accessed 18/01/2026).
2. Holden, A. and Holden, N. (2014) How many of our patients can really give consent - A perspective on the relevance of the Mental Capacity Act to dentistry. Dental Update. 41. pp. 46-48.
3. Emmett, C. (2007) The Mental Capacity Act 2005 and its Impact on Dental Practice. British Dental Journal. 203 pp.515-521.
4.Care Quality Commission (2023) Regulation 11: Need for Consent. Available at https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-11-need-consent#guidance (accessed 21/01/2026)
5. Care Quality Commission (2024) Assessment Framework. Available at: https://www.cqc.org.uk/guidance-regulation/providers/assessment/single-assessment-framework/safe/safe-systems-pathways-transitions (accessed 21/01/2026)
6. General Dental Council (2013) Standards for the Dental Team. Available at: https://standards.gdc-uk.org/ Accessed (21/01/2026)
7. Gov.UK (2015) Mental Capacity Act Code of Practice. Available from: https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice (Accessed 20/01/2026).
8. NHS (2024) Giving someone power of attorney. Available at: https://www.nhs.uk/conditions/social-care-and-support-guide/making-decisions-for-someone-else/giving-someone-power-of-attorney/ (accessed 21/01/2026)
9. Social Care Institute for Excellence (2010) Available from: https://www.scie.org.uk/mca/imca/info-for/health-social-care (Accessed 21/01/2026).
10. NSPCC (2022) Gillick Competence. Available at: Gillick competence and Fraser guidelines | NSPCC Learning (21/01/2026)
11.Gov.UK (n.date) Parental rights and responsibilities. Available at: https://www.gov.uk/parental-rights-responsibilities/who-has-parental-responsibility (accessed 21/01/2026)
12.Social Care Institute for Excellence (2022) Deprivation of Liberty Safeguards (DoLS) at a Glance. Available at: https://www.scie.org.uk/mca/dols/at-a-glance/ (accessed 21/01/2026)
13. Department of Health and Social Care (2021) Liberty Protection Safeguards: what are they. Available at: https://www.gov.uk/government/publications/liberty-protection-safeguards-factsheets/liberty-protection-safeguards-what-they-are (accessed 18/01/2026)