Mental Capacity Act

What is the Mental Capacity Act (MCA) 2005 – a quick history

- MCA has been in force since 2007, it applies to England and Wales
- **MCA framework**-It empowers people to make decisions for themselves wherever possible and provides framework to protect the people who lacks mental capacity to make their own decisions.
- **LPAs/Advance decisions**: MCA also supports those who have capacity who want to choose to plan for their future, such as appointing a power of attorney or making an advance decision.
- **Code of Practice**: All professionals have a duty to comply with the Act and its Code of Practice. It also provides support and guidance for informal carers.
- The Act introduces a new criminal offence of ill treatment or wilful neglect of a person who lacks capacity (Section 44).

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MCA - The 5 principles

The MCA has five key principles which emphasise its fundamental concepts and core values. These must be borne in mind when working with, or providing care or treatment for, people who lack capacity.

1. Presumption of capacity – every adult has right to make their own decisions.
2. Reasonable steps – person must be supported to make their own decisions
3. Unwise decisions – people have right to make what others may consider unwise decisions. They have different values, belief or preferences
4. Best Interests – anything done for person must be in their best interest
5. Least restrictive options – anything done must be least restrictive to their basic rights/freedoms.

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Who is affected by MCA 2005

- People aged 16 and over

- Those unable to make a decision ‘because of an impairment of, or a disturbance in the functioning of, the mind or brain.’

Conditions such as (not exhaustive):

Dementia, a learning disability, brain injury, autism spectrum disorder, depression, confusion associated with infection, unconsciousness.

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Using the Act

1. Consent
2. Mental Capacity Act assessment
3. Best Interests Decision

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Consent –

- Starting point for all decisions.
- Also the **legal foundation** for the majority of health and social care decisions.
- Definition : The **voluntary and continuing permission** of the person to receive particular treatment or care and support.
- A person evidenced to lack mental capacity cannot provide valid consent to treatment or care and support, even if they cooperate or actively seek it.

- **What information should be provided to the person?**
- The person needs sufficient information before they can decide whether to give their consent. The information needed is in three fold:

1: Nature – what care and treatment is being proposed and why?

2. Purpose – what are the benefits, negatives and alternatives

3. Consequences/risk -what will happen if the care or treatment do not go ahead.

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Key points to remember regarding Consent

- Consent can be written, oral or non-verbal. A signature itself does not prove the consent is valid. The most important point is to record the person's decision and the discussions that have taken place.
- Obtaining consent means providing the adult with appropriate information
- Consent is given freely (no coercion/control)
- No one can give consent on behalf of an adult who lacks capacity, unless the person holds a valid Lasting Power of Attorney or has been appointed as Deputy by the Court of Protection.
- An adult with mental capacity can refuse all care and support and this can not be overridden by the 'duty of care' of staff
- If a person cannot give consent due to the person lacking mental capacity, then the Mental Capacity Act will come in to effect

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Mental Capacity Assessment

- **The functional test of capacity:** (NB time and decision specific)

1. Understand the information relevant to the decision (Nature +purpose + consequences/risk)
2. Retain the information (only long enough to make decision)
3. Use or weigh that information (Accept and take account of that information)
4. Communicate the decision (any form of communication)

- **The diagnostic test of capacity**: Person has an impairment of, or disturbance in, the functioning of the mind or brain (it does not matter if this is permanent or temporary).

Causative Nexus must be established between functional test and diagnostic test of capacity.

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Assessing mental capacity- what information does a person need to understand?

Case law shows what judges have explored when they are considering various decisions – Capacity as to residence, as to contact with others and on Care.

LBX v K,L, M [2013] EWHC 3230 (Fam) - the judge broke down what relevant questions were needed (39 Essex Chambers)

Other useful resources:

https://mylife.enfield.gov.uk/enfield-home-page/content/safeguarding/mental-capacity-act/

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Proof

The burden of proof rests with the assessor. The assessor needs to prove the person they have assessed lacks mental capacity. The person being assessed does NOT have to prove they have mental capacity.

The standard of proof required is on **the balance of probabilities**. In other words, what is more likely than not. Objective reasons will be required to support your conclusions.

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Executive capacity:

Executive function is an umbrella term used to describe a set of mental skills that are controlled by the frontal lobes of the brain. When executive function is impaired, it can inhibit appropriate decision-making and reduce a person's problem-solving abilities. Planning and organisation, flexibility in thinking, multi-tasking, social behaviour, emotion control and motivation are all executive functions.

A common area of difficulty is where a person with, for example, an acquired brain injury gives coherent answers to questions, but it is clear from their actions that they are unable to give effect to their decision.

This is sometimes called an impairment in their executive function. The executive functions comprise those mental capacities necessary for formulating goals, planning how to achieve them, and carrying out the plans effectively.

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If the person cannot understand (and /or use or weigh) the fact that there is a difference between what they say and what they do when required to act, it can be said that they lack capacity to make the decision in question. However, this conclusion can only properly be reached when there is clear evidence of repeated difference between what the person says and what they do.

This means that in practice it is unlikely to be possible to conclude that the person lacks capacity as a result of their impairment on the basis of one single assessment.

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A person who makes a decision which others consider to be unwise should not be presumed to lack capacity. However, a series of unwise decisions may indicate an inability to use or weigh information.

Impulsivity arising from, for example, some Personality Disorders (often seen in people who have a history of trauma) or an inability to control one's actions, where issues of chronic alcohol or substance misuse are present, may also indicate an issue of executive functioning.

The challenge is one of assessing a person's decision making capacity when they can seemingly 'talk the talk' (decisional capacity), but can't 'walk the walk' (executive capacity) (frontal lobe paradox- discussed later), especially when we believe that this inability to 'walk the walk' may be 'because of an impairment of, or a disturbance in the functioning of, the mind or brain'.

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Screening for possible executive impairment

The clinical history will often provide clues suggestive of executive impairment. A pre existing mental health diagnosis may raise the suspicion of executive impairment. The person with executive impairment may show the following signs:

- Unable to translate intention into action
- ‘Full of promises’ and plausible
- Apathetic
- Inability to initiate, plan and sequence activities
- Struggling with new situations (better with familiar)
- Behaviour is aimless, impulsive, and fragmented
- Unable to monitor and evaluate their own actions
- Unable to think flexibly or abstractly
- Less able to adapt to change
- Black and white thinking style
- Lack of a filter in social situations

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Frontal lobe paradox

People with executive impairment can often present very well in a formal assessment of cognition and capacity. They can often mask their deficits, and often unaware they are doing so. Despite this, there is often signs that they still struggle in day to day life. This is known as the ‘frontal lobe paradox’.

An example of this difficulty: is where a person with an acquired brain injury gives superficially coherent answers to questions, but it is clear from their actions that they are unable to carry into effect the intentions expressed in those answers. In other words, they are good in theory but poor in practice.

Two of the main reasons for this are that people with executive impairment are often not aware of any cognitive deficit (problems with awareness of deficit) and are unable to think about or reflect on their own cognitive processes (problems with metacognition or ‘thinking about thinking’).

Problems with executive function might be suspected if someone seems, in theory, to appreciate and understand their situation, but is then is struggling to elicit the relevant bits of information and use them in the right context. They may also struggle to act upon or execute a decision.

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Overlap and continuum challenges with executive capacity

To further complicate the picture, many of the traits and behaviours observed in executive impairment vary in degree, (they exist on a continuum) and are also observed in the normal healthy population (they overlap with health population). This means it can be difficult to know if the behaviour or trait is pathological and therefore likely to be impairing capacity.

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Key point for executive capacity

- Executive impairment can affect decision making capacity.
- It is often overlooked, resulting in potential exposure of a vulnerable person to risk.
- It can be very difficult to assess the effect of executive impairment on mental capacity for a number of reasons - repeated assessment of capacity, supported by collateral information and real-life functional assessment are recommended.
- The term ‘executive functioning’ is not referred to in the Act or the CoP and should be included in clearly and explicitly in the Act
- If you have concerns that a person’s executive functioning may be affecting their decision-making capacity, this needs to be discussed with the MCA & DoLS Team 0203 855 6299

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Where and which staff can use the Act?

There is no statutory limitation on where the MCA can be used (excepts DoLS). The Act can be used everywhere in England and Wales, including prisons. Some exceptions for patients detained under the Mental Health Act 1983 may apply.

All staff working with people who lack capacity are affected by the Act. In addition, relatives, carers and voluntary services must use the legislation if they provide support to those who lack capacity.

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Best interests:

Best interests decision is only considered if the person has been assessed as **lacking mental capacity**.

Any decision made under this framework must be in the person's best interest and least restrictive to their human rights and freedoms.

Checklist :The Act provides a statutory checklist that must be followed when making a best interests decision. The decision maker needs to consider the following points: Have regards to all relevant information, the person's wishes/feeling, consult LPA/EPA attorney, Deputy appointed by the Court, consult others (family, support network and anyone who has interest in the welfare of P), consider least restrictive options, can the decision wait, and do not discriminate.

A balancing exercise, a balance sheet of positive and negatives connected to the decision is a good approach

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Limits

The best interest checklist can be used to make all decisions around finances, health and social care, but it cannot be used to make decisions about:

- voting
- sexual relations
- marriage
- deprive person of their liberties
- adoption or divorce
- Signing/Executing legal documents (such as terminating tenancy/phone contracts)

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Legal protection for the decision-maker

By using the best interests checklist, the decision- maker is protected by the defence contained in section 5 of the Act which states they will ‘not incur any liability’ if they follow the Act properly.

A best interest decisions/meetings therefore must be recorded appropriately.

Actions covered: being assessed (e.g. Care Act), personal care, washing, eating, help with mobility, education and leisure activities, buying necessary goods, helping to move home, health care/medical examination, giving medication, providing nursing care.

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Independent mental capacity advocates (IMCA)

If the person lacks capacity and has no suitable friend or family to support them, an IMCA must be appointed.

IMCA must be appointed for:

- Serious medical treatment
- Accommodation (28 consecutive days in a hospital or 8 consecutive weeks in a care home)
- Deprivation of Liberty Safeguards

In addition, an IMCA **may** be appointed for:

- Care reviews
- Safeguarding adults from abuse cases

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