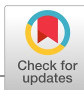

ARTICLE

Mental capacity in practice part 1: how do we really assess capacity?

Chloe Beale, James Lee-Davey, Tennyson Lee & Alex Ruck Keene

Chloe Beale, MBBS, MRCPsych, LLM, is a consultant liaison psychiatrist with the Homerton Psychological Medicine team at Homerton University Hospital, London, trust lead for suicide prevention for East London NHS Foundation Trust and an honorary clinical senior lecturer at Queen Mary University of London, UK. **James Lee-Davey**, MBBS, BSc, MRCPsych, MA, is a consultant liaison psychiatrist in the Department of Psychological Medicine, Royal London Hospital, East London NHS Foundation Trust, and an honorary clinical senior lecturer at Queen Mary University of London, UK. **Tennyson Lee**, FFCH, FRCPsych, is a consultant psychiatrist in psychotherapy and a psychoanalyst. He is clinical lead in Deancross Personality Disorder Service, East London NHS Foundation Trust, and co-director of the Centre for Understanding of Personality Disorder (CUSP), linked to the Wolfson Institute of Preventive Medicine at Queen Mary University of London, UK. **Alex Ruck Keene**, KC (Hon), is a specialist mental capacity barrister at 39 Essex Chambers in London, UK. He is also a Wellcome Research Fellow (on the Mental Health and Justice Project) and Visiting Professor at King's College London, and a visiting senior lecturer at the Institute of Psychiatry, Psychology & Neuroscience, King's College London, UK.
Correspondence Dr Chloe Beale. Email: chloebeale@nhs.net

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SUMMARY

Significant problems exist in understanding and implementing the Mental Capacity Act 2005 (MCA) despite it having been in place in England and Wales for more than 15 years. Although many guidelines exist on the assessment of capacity, it is difficult to apply such guidance in practice, given the complexity of actual situations. We may know the stages of the test for capacity, but do we really understand what they mean and how to assess them? In this, the first of two articles examining the MCA and challenges in its application, we add to existing legal guidance to explore capacity assessment in detail using a clinical scenario, and use case law and case studies to illustrate the subtleties and difficulties that may arise.

LEARNING OBJECTIVES

After reading this article you will be able to:

- carry out and document a more thorough capacity assessment for decisions relevant to your own practice
- understand the importance of the causative nexus in assessing capacity and recognise the limitations of the capacity test in capturing the complex factors that influence decision-making
- identify some of the relevant case law and sources of information in order to inform your own practice.

KEYWORDS

Consent and capacity; Mental Capacity Act; ethics; psychiatry and law; education and training.

Around 2 million people in England and Wales may lack the capacity to make some or all decisions for themselves at some point in their lives (Care Quality Commission 2013). The Mental Capacity Act 2005 (MCA) provides a statutory framework to respond to such a situation and sets out who can take decisions, in which situations and how they should go about this.

Despite being in place for more than 15 years, problems with the understanding and implementation of this legislation persist (Emmett 2013a, 2013b; Evans 2007; Hotopf 2005; Jackson 2002; Kane 2022; Kim 2022; Luke 2008; *Esegbona v King's College Hospital NHS Foundation Trust* [2019]). Mental capacity assessments are often inconsistently applied and do not make adequate use of MCA criteria (Brown 2013; Owen 2013). Even in settings such as the Court of Protection, the judges do not necessarily agree with the experts and professionals as to whether the person has capacity to make a certain decision (Kane 2021). It is therefore unsurprising that difficulties arise in the application of such guidance in day-to-day practice, when real situations are often very complex and assessments nuanced. Additional difficulties arise at the interface between the MCA and the Mental Health Act 1983 (MHA) (Department for Constitutional Affairs 2015).

This article adds to existing legal guidelines (Mental Health and Justice 2022; Ruck Keene 2022a) by presenting a clinical scenario and addressing application of the MCA. We then detail some conceptual problems with the MCA and pitfalls to avoid in assessing capacity.

We use recent case law and the fictitious clinical scenario below to illustrate the subtleties and challenges that may arise. We have deliberately not offered clarity on whether or not the person described in the cases has capacity for the decisions in question. This emphasises that the critical issue is whether you have taken reasonable steps to establish whether or not the person has capacity, and whether your belief that they do (or do not) is reasonable. This, in turn, means that it is possible for two assessors to disagree while both being reasonable in their belief about the person's capacity. Capacity is not a yes/no answer and we do well to steer away from treating it as a tick-box exercise. Instead we aim to provide the reader with a set of principles and tools to better manage the complexity of capacity assessments.

Clinical scenario

Mr A is a 47-year-old man who has been detained under section 3 of the MHA 1983 for the past 3 months. He has a diagnosis of schizophrenia and this is his fifth admission to hospital. He is being treated with a depot antipsychotic and occasional benzodiazepines for agitation. He is slowly improving but remains psychotic and does not believe he is unwell. His consent to treatment is due. Over the past few weeks he has been complaining of intermittent epigastric pain and nausea, and has had an

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episode of melaena. Blood tests have shown a mild anaemia. He has lost some weight since admission. You have discussed the situation with a gastroenterologist, who advises that Mr A should have an endoscopy. Mr A refuses this. How will you approach the assessment of capacity regarding this patient's physical and mental health?

Decisions and frameworks

Where both the MHA and MCA may apply, clinicians may struggle with the interface; such dilemmas are well-documented (e.g. Dawson 2006; Fanning 2016; Hale 2017; Luke 2008; National Confidential Enquiry into Patient Outcome and Death 2017; Richardson 2007; Ruck Keene 2013; Wessely 2018). Mr A faces decisions about both his physical and mental health, both requiring a capacity assessment if his decision-making ability is in doubt. In relation to the treatment for psychosis, it is necessary to assess his capacity to consent in order to decide which limb of section 58 of the MHA is going to be relied on. Consent to an endoscopy is unrelated to the MHA: what is being considered is not medical treatment for mental disorder but a procedure to investigate his epigastric pain and nausea. Despite the fact that he is a patient detained under the MHA, the test is that set out in the MCA – because the basis for treatment will either be (a) capacitous consent or (b) the operation of section 5 of the MCA.

A capacitous refusal to consent to the endoscopy is a bar, whereas a capacitous refusal to consent to treatment for psychosis under the MHA is not. We have chosen to discuss the principles of the MCA in relation to the endoscopy, as this decision falls within the remit of this Act. In describing how to approach the test for capacity, we focus on the decision to take depot antipsychotic medication, as it is this for which a psychiatrist will be the decision maker. Although this is treatment under the MHA, the MHA Code of Practice (Department for Constitutional Affairs 2015) makes clear that, for purposes of determining this issue, while the statutory language is that of 'capable', the test is actually that under the MCA (para 24.31).

Principles of the MCA

Each principle of the MCA needs to be taken into account during assessments of capacity (Box 1).

BOX 1 Assessment of capacity under the Mental Capacity Act 2005

Section 1 of the MCA sets out the five statutory principles:

1. a person must be assumed to have capacity unless it is established that they lack capacity
2. a person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success
3. a person is not to be treated as unable to make a decision merely because they make an unwise decision
4. an act done or decision made under the MCA for or on behalf of a person who lacks capacity must be done or made in their best interests
5. before the act is done or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action

1. **Presumption of capacity** The presence of a mental disorder should not lead us to automatically doubt Mr A's capacity. However, if sufficient concern exists and where there may be legitimate doubt as to capacity to make the relevant decision (here, to refuse endoscopy), the presumption of capacity cannot be used to avoid assessing and determining capacity (Ruck Keene 2022a; *Royal Bank of Scotland Plc v AB* [2020]).

   Certain populations, such as those with substance use problems, may be regarded by professionals as making a 'lifestyle choice', eliciting negative reactions. Alcohol has been identified as a significant factor in the death of a person who often had multiple complex needs, and where refusal of care was common (Alcohol Change UK 2019; Preston-Shoot 2022). This report noted that a presumption of capacity was 'sometimes used by a practitioner faced with a person who is self-neglecting and refusing to engage, to reach a superficial conclusion that the person has capacity'. The report also cautioned that the ability to make a simple decision should not be used as evidence that a person can make a complex one.

   Regarding Mr A, for a patient in a psychotic episode who is refusing investigation or treatment it is likely reasonable to want to take the necessary steps to establish their ability to make certain decisions.
2. **Practicable steps** It is important to take all practicable steps to help Mr A make a decision. This means clinicians cannot treat the capacity assessment as the starting gun for telling him what they want to do. Unless it is an emergency, it is unfair to tell him he needs an endoscopy in the same conversation in which his capacity will be assessed. What information has he been given? Is he in a position to make use of written information or to ask questions about the nature of the procedure? If presumption of capacity is being relied on then it may be reasonable to present the information and the consent form simultaneously, but

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if a lack of capacity is suspected then there is a duty to help patients make the decision before considering taking it for them. Listing the proposed treatment and the alternatives may be helpful.

3 **Unwise decisions** 'If P has capacity to make a decision then he or she has the right to make an unwise decision and to suffer the consequences if and when things go wrong' (*A Local Authority v JB* [2021]). People with psychosis are as entitled to make objectively unwise decisions as anyone else regarding their physical health, provided this is a capacitous decision. However, whether something is 'unwise' can be complex and involves a judgement on the part of the assessor (see also 'Conceptual problems in the MCA' below).

4 **Best interests** Mr A's best interests may not be synonymous with recommended medical advice. Best interests decisions need to take a number of factors into account: not just those seen as clinically most appropriate, but also those relating to quality of life, comfort and Mr A's wishes and feelings. Although the law says that the 'balancing sheet' exercise on making best interests decisions should not give greater weight to any one of these aspects, decisions from the courts are increasingly suggesting that considerable weight should be given to the person's wishes and feelings and there should be a very compelling argument to override these (Ruck Keene 2015; *Aintree University Hospitals NHS Foundation Trust v James* [2013]; *Wye Valley NHS Trust v B* [2015]).

5 **Least restrictive** In terms of Mr A's endoscopy, a clinician may want to consider whether it is possible to use a less invasive test that might require a lesser degree of sedation and restraint, such as imaging or blood test. It may be the case that very restrictive actions are truly also the least restrictive way of achieving the necessary outcome, but there needs to be evidence that this has been considered.

BOX 2 Who is the decision maker in a capacity assessment?

The Mental Capacity Act Code of Practice states:

'If a doctor or healthcare professional proposes treatment or an examination, they must assess the person's capacity to consent. In settings such as a hospital, this can involve the multi-disciplinary team (a team of people from different professional backgrounds who share responsibility for a patient). But ultimately, it is up to the professional responsible for the person's treatment to make sure that capacity has been assessed.' (section 4.40)

'More complex decisions are likely to need more formal assessments […]. A professional opinion on the person's capacity might be necessary. This could be, for example, from a psychiatrist, psychologist, a speech and language therapist, occupational therapist or social worker. *But the final decision about a person's capacity must be made by the person intending to make the decision or carry out the action on behalf of the person who lacks capacity – not the professional, who is there to advise.*' (italics added) (section 4.42)

(Department for Constitutional Affairs 2007)

Who is the decision maker?

Having applied the five principles, the next step is to determine who is the decision maker. For consent to treatment under the MHA it will be you as the psychiatrist, but you are not the person performing the endoscopy so should not usually be the one to make the final decision on Mr A's capacity to consent here. What role might you play in supporting the gastroenterologist to assess capacity? Psychiatrists, especially in liaison settings, may often be asked to see patients refusing intervention in order to perform a 'formal' capacity assessment (Kane 2022). This may be based on a misunderstanding of the MCA, as all clinicians are expected to be competent to assess capacity (Box 2).

Regarding Mr A, your role is to give an opinion as to whether the mental disorder is affecting his decision-making, to assess whether his decision-making can be optimised and to help the gastroenterologist approach the patient, perhaps jointly assessing capacity if appropriate. Obviously in some cases psychiatrists are needed to give a second opinion because of the complexity of the situation, commonly seen in the Court of Protection (Ruck Keene 2019), but theirs should not be the only capacity assessment for this procedure.

Assessing capacity

Section 2(1) of the MCA states 'a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or the brain'.

The Supreme Court in *A Local Authority v JB* [2021] has made clear that it is necessary to start with the 'functional' question of whether the person can make the decision, and only if the person cannot make the decision, then to go on to ask why. (Confusingly, the MCA Code of Practice puts the 'diagnostic' test first, in contrast to the Act itself. Case law has established this to be incorrect (Ruck Keene 2022b)). As amplified in legal

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guidance, this can usefully be broken down into three questions (Ruck Keene 2022a):

1 is the person able to make a decision? If they are not:
2 is there an impairment or disturbance in the functioning of the person's mind or brain? If so:
3 is the person's inability to make the decision because of the identified impairment or disturbance?

The functional test

For most clinicians, the functional test will be the aspect of the MCA with which they are most familiar. This is the four-stage test which you must begin with. For each stage you should give the evidence for your opinion and demonstrate how the person was supported. It is not enough to say they do not have capacity because they do not understand. This was highlighted in the case of *AMDC v AG & Anor* [2020]: 'An expert report should not only state the expert's opinions, but also explain the basis of each opinion. The court is unlikely to give weight to an opinion unless it knows on what evidence it was based and what reasoning led to it being formed'.

Section 3(1) of the MCA states that a person is unable to make a decision if they cannot:

(a) understand information relevant to the decision to be made; or
(b) retain that information; or
(c) use or weigh that information as part of the decision-making process; or
(d) communicate their decision (by talking, using sign language or any other means).

An analysis was conducted (Kane 2021) of all published cases from courts in England and Wales containing rationales for incapacity or intact capacity in order to develop a 'typology of capacity rationales or abilities'. Relationships between the typology and legal criteria for capacity and diagnoses were then analysed. Rationales most frequently linked to the MCA criterion 'understand' were the ability to grasp information or concepts (43%) or to appreciate (42%), and those most frequently linked to the MCA criterion 'use or weigh' were the abilities to appreciate (45%) or to reason (32%). Appreciation was the most frequently cited rationale across all diagnoses. The analysis also found that judges often used rationales without linking them specifically to any MCA criteria (42%).

A later paper by the same authors (Kim 2022) looking at the same data made several recommendations to increase reliability and transparency of assessments. These include:

- being explicit about which MCA criterion is being applied
- using the criterion of understanding only in its narrow sense of grasping relevant information
- when applying the 'use or weigh' criterion, being explicit about which rationale(s) are at play.

Kane, Kim and colleagues (researchers from Mental Health and Justice, a multidisciplinary research initiative) have used their findings to create the guidance website www.capacityguide.org.uk, which readers are encouraged to visit. Here, we consider how documentation of capacity assessment might look in practice.

Understand

It is important to note the salient points that the person requires to make a decision and not to expect a higher level of understanding than for someone with whom you are not questioning capacity. This is why it is important for the relevant expert to assess capacity for each decision – as a psychiatrist, how could you be expected to know the salient information about endoscopy? However, the psychiatrist is clearly the appropriate decision maker when assessing capacity to consent to antipsychotic treatment.

You need to demonstrate how you have arrived at your conclusion; directly quoting the patient is important here. Remember, in any assessment of capacity you are making a decision that you might be asked to defend in court. If you have demonstrated the patient's view in their own words you are less likely to misinterpret them. It will never be enough to simply say 'he does/doesn't understand the information' in order to evidence your opinion. Mr A has delusional beliefs but does that prevent him from understanding what is being said to him?

Documenting what Mr A makes of the salient points and how much he was able to tell you about the reasons for the decision, using quotes, is recommended rather than writing a statement such as 'He doesn't fully understand because he has delusions and believes we are trying to harm him'. For example,

> 'Mr A firmly believes that the only reason he keeps being admitted to hospital is because, when he stops the depot, the government doctors can tell that the tracking device has faded and they bring him back in to insert new ones. He told me that he is sick of being told that the depot is a treatment for schizophrenia; as far as he is concerned, this is untrue. He does not agree that when he stops the depot he is affected in other ways (for example, he sometimes becomes dehydrated because he is suspicious of the water supply; he hears voices which frighten him and walks the street for hours in the night to avoid them; sometimes they have upset him so much he has shouted back or smashed things in his flat and the police have been called). He recognises that there is

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'a correlation between these things happening and stopping the depot, but thinks it is because the government know when he has stopped it and increase their persecution. I asked if it would be worth taking the depot in order to avoid this cycle happening repeatedly and he said "I get it, you want me to give in, you want all the control".'

Retain

A common misconception is that a person needs to retain information for a significant period, for example between ward rounds or until the next day. He does not need to remember the information forever, or even until the next day or the next hour. He just needs to retain it long enough to use it to make a decision 'at the material time'. If he is able to consider the relevant information and come to a decision in a few minutes such that he would be judged to be capacitous, then it does not matter if a short time later he has forgotten much of the information.

'Mr A was annoyed to be having this discussion again as he says he has made his views on depot medication clear.'

Weigh in the balance

This is perhaps the most difficult to evidence but also the most likely aspect of the four-stage test where the balance may fall on the side of lacking capacity. Arguably, it may also be the aspect giving rise to most disagreement. Neither the MCA Code of Practice (Department for Constitutional Affairs 2007) nor the National Institute for Health and Care Excellence (NICE) guidelines on decision-making and mental capacity (NICE 2018) give detail on what constitutes an inability to use or weigh.

A key thing to remember here is to be mindful of the influence of one's own values when assessing others. Often we make the mistake of thinking someone is unable to weigh up the pros and cons because they simply do not see the 'cons' or will not accept the medical view. However, this is a misunderstanding. Just as best interests may not be the recommended medical treatment, the ability to weigh up means the ability to attach weight to different options which may not be the same as the weight you attach; their reasons may be very difficult to understand (*King's College Hospital NHS Foundation Trust v C and V* [2015]). This is where it is very important to understand as much as you can about the patient and what is important to them when they are well. Mr A may be someone who prefers to manage his own health and avoids going to the doctor. Perhaps he has had bad experiences or has particular views about medicine and this means that he would be likely to decline medication or investigations, regardless of whether he was mentally unwell.

Again, it is important to document Mr A's beliefs and behaviour:

'Mr A has, for many years, believed that doctors wish to experiment on him. Even when his mental state is at its most stable, he is generally avoidant of medical attention unless he is in severe pain. When he broke his wrist two years ago he allowed his friend to take him to hospital and accepted a plaster cast and painkillers. He never attended fracture clinic follow-up. He rarely goes to his GP [general practitioner] and he ignores requests to come in for health checks or screening. He allows his CPN [community psychiatric nurse] to visit monthly to administer depot, although he does not like or want this and inevitably stops answering the door after a while. When he stops his depot his mental health deteriorates. When he is acutely unwell his suspicion and hostility towards doctors intensifies and he hears voices of people talking about removing his internal organs. He believes that doctors wish to change his DNA by giving him medication. He actively resists any form of injection, blood tests or investigation as he believes they will be used to insert a tracking device. Mr A is agreeing to have his depot "because that's the only way you people will let me out of this place". When asked if he will take it after discharge he replies "I haven't got a choice, have I? You people will do what you want to do, I have no power. You'll get what you want in the end". When asked if there is any benefit to the depot he says "You benefit from it. You get to control me". I reminded him that he had said taking the depot gets him out of hospital and he became irritable, saying "I have to comply with the regime to earn my freedom, that is no benefit to me".'

Communicate

The Code of Practice (Department for Constitutional Affairs 2007) notes that the inability to communicate their decision is likely to apply to very few people, but gives examples including people who are unconscious or in a coma, or those with locked-in syndrome.

'Earlier in his admission, Mr A had marked thought disorder with pressured speech. When asked about taking medication his speech would become instantly derailed. He would say "I'm not taking that stuff" but would then talk wildly off the point about things which were not at all relevant. It was impossible to follow his train of thought. When the question was repeated, he said something completely unrelated. His thought disorder seemed to be affecting his ability to focus on the conversation long enough to discuss the question; however, his communication of his wishes was clear in that when offered medication he said 'no no no no' and walked away from the nurse.

The diagnostic test

This term (which does not appear in the MCA) is confusing as there does not have to be an actual neuropsychiatric diagnosis – the impairment can

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be a temporary state. The question asked is: Is there a disorder of, or disturbance in the functioning of, the mind or brain? In Mr A's case he has an established diagnosis of schizophrenia and this is currently symptomatic, so he meets this criterion.

The causative nexus

This final aspect of the capacity assessment is often overlooked and misunderstood. Just because someone has a mental disorder *and* fails an aspect of the four-stage test, it does not mean the two are linked. You will need to establish a causal link (the causative nexus), i.e. be satisfied that the inability to make a decision is because of the impairment and, again, be prepared to demonstrate this (*PC and NC v City of York Council* [2013]). This reminds us of the need to not assume that having an impairment or mental disorder means that someone lacks capacity.

When supporting the gastroenterologist in their assessment, the psychiatrist can be particularly helpful in determining this aspect. Mr A is currently psychotic but the gastroenterologist will have to consider whether that renders him incapable of making an informed choice about whether or not to consent to an investigation for likely upper gastrointestinal bleed.

Box 3 gives a case example of the difficulty of establishing the causative nexus.

Conceptual problems in the MCA

Regarding unwise decisions, in the context of mental illness in particular, there is often uncertainty in applying MCA criteria. A major reason for this is that the concept of capacity employed in the MCA overlooks the inherent values-based ('normative') judgements regarding whether an individual is using or weighing information appropriately (Banner 2012, 2013; Freyenhagen 2013; Richardson 2013). The 'cognitive' approach of the MCA assumes that capacity can be an objectively measurable phenomenon, which has been disputed: 'Where normative standards are universally agreed upon, they are conceptually and pragmatically unproblematic. However, […] it is by no means clear what normative standards discipline such judgements, or whether they might diverge between clinicians and patients' (Banner 2012). Similarly, Stammers & Bortolotti (2020) discuss the potential challenges that arise owing to the influence of the observer's values, which sit outside the Act, as well as the importance of recognising the influence of stereotypes and implicit biases on decision-making in relation to mental capacity. Such biases may affect several areas, including how information is communicated, interpreting assessment criteria and best interests decisions.

It has also been noted that the MCA model is a strongly cognitive one, which implies highly rationalist standards for patients – but decisions are often based on emotions, values or intuitive factors not totally conscious to the decision maker (Breden 2004; Ruck Keene 2017).

Pitfalls to avoid

Here we describe some potential difficulties in assessing capacity, with examples from recent case law.

BOX 3 The causative nexus: which impairment is to blame?

TM, a 42-year-old man from Zimbabwe, objected to a proposed bilateral below-knee amputation, without which his treating clinicians believed he would suffer life-threatening complications. He was admitted to hospital confused with cellulitis, acute kidney injury and anaemia and had bilateral frostbite to his feet. He tested positive for HIV, with high viral load and low CD4 count. He was found to lack capacity to make decisions regarding his medical treatment. Computed tomography of the brain showed non-specific abnormalities with several potential causes, including HIV-related disease, inflammation or progressive multifocal leukoencephalopathy. A depressive episode was also considered possible. TM was not able to give a detailed account of his life or treatment. He did not engage with discussions regarding treatment and refused surgery, and believed he would get better by himself.

This case gave further guidance on the causative nexus: if there are several possible causes of the lack of capacity, we do not have to be able to pin it down with certainty to one of those causes. Justice Hayden found that there were several possible reasons why TM might lack capacity, including depressive illness, progressive multifocal leukoencephalopathy and white matter abnormalities seen on imaging: 'It is clear therefore that there are a number of identified pathologies which separately or in combination are likely to explain the disturbance or functioning in TM's mind or brain […] It is a misunderstanding of section 3 MCA 2005 to read it as requiring the identification of a precise causal link where there are various, entirely viable causes. Insistence on identifying the precise pathology as necessary to establish the causal link is misconceived' (para. 37).

This is a welcome recognition that people often have several things going on and it can be clinically impossible to pick apart thoughts, beliefs and cognitive processes and know exactly which is linked to which condition (or to none).

(*Pennine Acute Hospital NHS Trust v TM* [2021])

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> **BOX 4** Lack of engagement
>
> QJ was an 87-year-old man with a diagnosis of vascular dementia. He did not want to stay in a care home and had been refusing food. It was unclear whether he had capacity to make decisions related to his medical care.
>
> The treating consultant concluded that he did not have capacity to make decisions about artificial nutrition, noting that QJ talked minimally, said nothing to certain questions and appeared unconcerned: 'It may be that he simply did not want to talk to me but […] I did not sense any evidence of him being able to weigh up or retain the information' (para. 19).
>
> However, Justice Hayden emphasised that lack of capacity cannot be established merely by reference to a person's condition or an aspect of behaviour, i.e. a reluctance to answer certain questions does not mean a person is unable to answer.
>
> (*QJ v A Local Authority & Anor* [2020])

Full/fully

> 'Mr A does not fully understand the proposed treatment, therefore he lacks capacity.'

If you expect your patient to be able to demonstrate a 'full' understanding of the proposed treatment, you are asking for a higher level of understanding than is asked of the average layperson. We do not expect Mr A to understand the detailed pharmacokinetics and pharmacodynamics of flupentixol, nor to explain to us step-by-step what a gastroenterologist will do with their endoscope. This would suggest a 'full' understanding. He needs to understand only *enough* (the salient points).

Lack of engagement

> 'I introduced Mr A to Dr B, the gastroenterology consultant. Mr A did not want to speak to us. He said that he was not interested in anything we had to say and then he turned his back on us and would not speak further, even when Dr B explained that we would have to make a decision in his best interests if he wouldn't discuss it.'

It may be tempting to conclude that a patient who does not engage and who is judged to have an impairment in the functioning of the mind, such as a psychotic disorder, lacks capacity; however, we should not assume that a patient's lack of engagement denotes a lack of capacity. If you suspect a lack of capacity, the onus is on you to explain why you have a reasonable belief that this is the case. It is not on your patient to prove that they do have capacity. The MCA Code of Practice states that nobody can be forced to undergo an assessment of capacity (Department for Constitutional Affairs 2007: section 4.59). If repeated attempts to engage the patient fail, an application to the court may be required (Ruck Keene 2022a), although only if the urgency of the situation allows. If the situation is very urgent and you can demonstrate a reasonable belief in lack of capacity, clinicians may take action (if the steps are necessary and proportionate to the risk of harm).

Box 4 outlines a recent case example where engagement was challenging.

Opinion on capacity which is not supported by evidence

> 'Mr A has capacity because he is able to understand, retain, weigh up and communicate his decision.'

There is increasing expectation – particularly within mental health services – that clinicians will consider patients' decision-making capacity. Although well-meant, this expectation may have led, unfortunately, to the treatment of capacity assessment as a tick-box exercise, with busy clinicians hurriedly writing out a statement to the effect that the patient has capacity but without any detail or evidence. A good example is the scrutiny regarding capacity assessments for people admitted informally to hospital. Psychiatric admission equates to confinement, so clinicians must establish whether or not a deprivation of liberty is occurring. Even 'voluntary' patients are not truly free to leave whenever they want, and are likely to be subject to some form of assessment before being permitted to exit what is often a locked ward. The wish to leave may even result in emergency detention under the MHA. So it is reasonable to consider capacity to consent to such restrictions. However, time constraints may lead busy admitting clinicians to make a hurried statement that an informal patient has capacity in order to fulfil governance requirements rather than taking the time to carry out and document a proper assessment. That said, people with a mental disorder are entitled to the presumption of capacity, which risks becoming confused with having capacity. It is more in keeping with the spirit of the law to document that there is no reason to doubt the presumption of capacity, rather than to state Mr A has capacity for to make a decision without having documented an assessment.

Offering an opinion on capacity for a situation in which you are not the decision maker

In liaison psychiatry in particular you may be asked to assess capacity to consent to a physical intervention under the misapprehension that there is something more 'formal' about a psychiatrist doing it. We explained above why psychiatrists should avoid falling into this trap (see also Box 2).

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Reasonable belief

> 'I am unable to assess Mr A's capacity because I cannot be fully sure of his understanding.'

Clinicians need only to have a *reasonable belief* that the patient has, or lacks, capacity, following *reasonable steps* to ascertain this (Department for Constitutional Affairs 2007: para. 4.44). In the Court of Protection, the standard of proof is civil, not criminal. This is to say that you do not have to prove 'beyond a reasonable doubt' that someone has or lacks capacity, only that you are satisfied 'on the balance of probabilities'. Put another way, you only need to be 51% sure of your assessment. Acknowledging this uncertainty also helps us to hold in mind the changeable nature of mental capacity in many cases and the vital importance of reassessing where appropriate and ensuring that every relevant decision involves a fresh assessment. Although this article is concerned with assessment of capacity in a clinical context, it is wise for clinicians to bear in mind the expected standard of professional reports in the Court of Protection (Curtice 2022). This can provide a useful guide and reminder of the necessary rigour in a good-quality capacity assessment.

Conclusions

Capacity assessment is rarely simple and should be taken seriously. The focus on capacity assessment in psychiatric settings is well-meant but may lead to it becoming process-driven and therefore meaningless. All psychiatrists should be skilled in assessing capacity and advising others on how to go about it.

In this, the first article in a two-part series, we have summarised the fundamentals of capacity assessment, with reference to recent legal commentary and case reports to highlight the key principles and their application, and to help avoid common misunderstandings and pitfalls in assessments.

Our second article (Beale 2022) will explore capacity assessments in the context of suicidal acts.

Author contributions

C.B. drafted the article and J.-L.D., T.L. and A.R.K. made written contributions. All authors agreed the final content.

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Declaration of interest

None.

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MCQ answers
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MCQs

Select the single best option for each question stem

1 Which of the following is not a statutory principle of the Mental Capacity Act (MCA)?
- a an act done, or decision made, under the MCA for or on behalf of a person who lacks capacity must be done, or made, in their best interests
- b a person must be assumed to have capacity unless it is established that they lack capacity
- c a person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success
- d the final decision about a person's capacity must be made by the person intending to make the decision or carry out the action on behalf of the person who lacks capacity
- e a person is not to be treated as unable to make a decision merely because he makes an unwise decision.

2 In the scenario above where the patient refuses a proposed medical investigation (oesophago-gastro-duodenoscopy), who should assess capacity?
- a consultant psychiatrist
- b trainee psychiatrist
- c gastroenterologist
- d nurse
- e it does not matter who assesses.

3 Regarding the presence of an impairment or disturbance in the functioning of the person's mind or brain:
- a the term 'diagnostic test' does not appear in the MCA
- b the impairment does not need to be a confirmed neuropsychiatric diagnosis
- c the impairment can be temporary or permanent
- d a schizophrenic illness may count as an impairment
- e all of the above.

4 Regarding the causative nexus:
- a a single process needs to be identified
- b only medical diagnoses can be considered
- c a psychiatric illness alone is not sufficient
- d you do not need to identify one specific cause if there are several viable impairments
- e evidence shows that the causative nexus is often taken into account when assessing capacity.

5 In assessing capacity:
- a the standard of proof that must be achieved is 'beyond reasonable doubt'
- b the MCA criteria are usually consistently and robustly applied by clinicians
- c the assessed person has to prove they have capacity
- d the presence of an impairment or disturbance is enough to show a person lacks capacity without needing to show a causation
- e where concerns exist, the presumption of capacity should not be used to avoid taking responsibility for determining capacity.

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