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What makes a good assessment of capacity?

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This document was produced by the Mental Capacity Advisory Group, a sub-group of the British Psychological Society's Professional Practice Board and has involved cross-speciality input covering a broad array of contexts in which Mental Capacity Act (MCA) assessments may be completed by psychologists.

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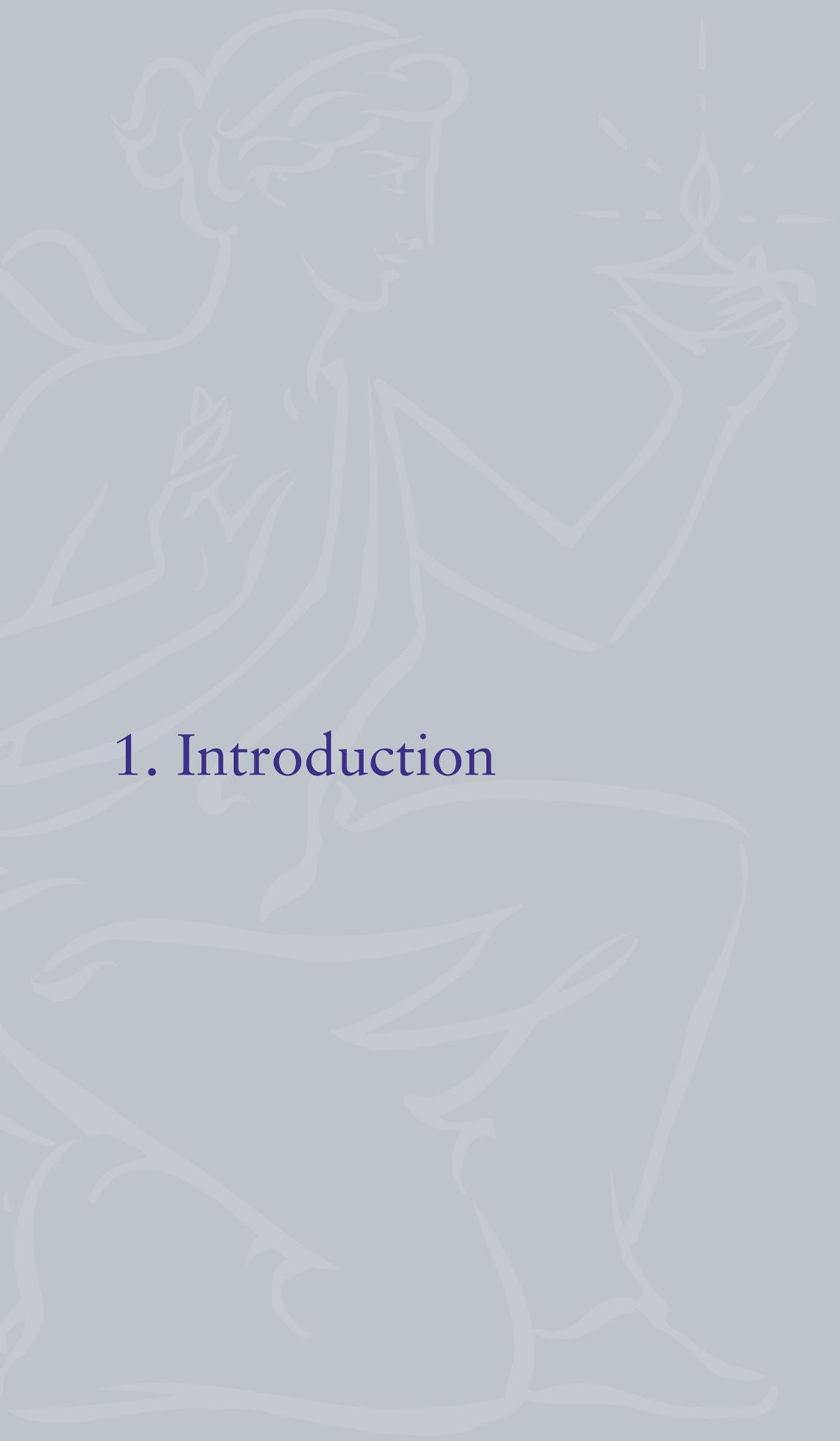
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1. Introduction

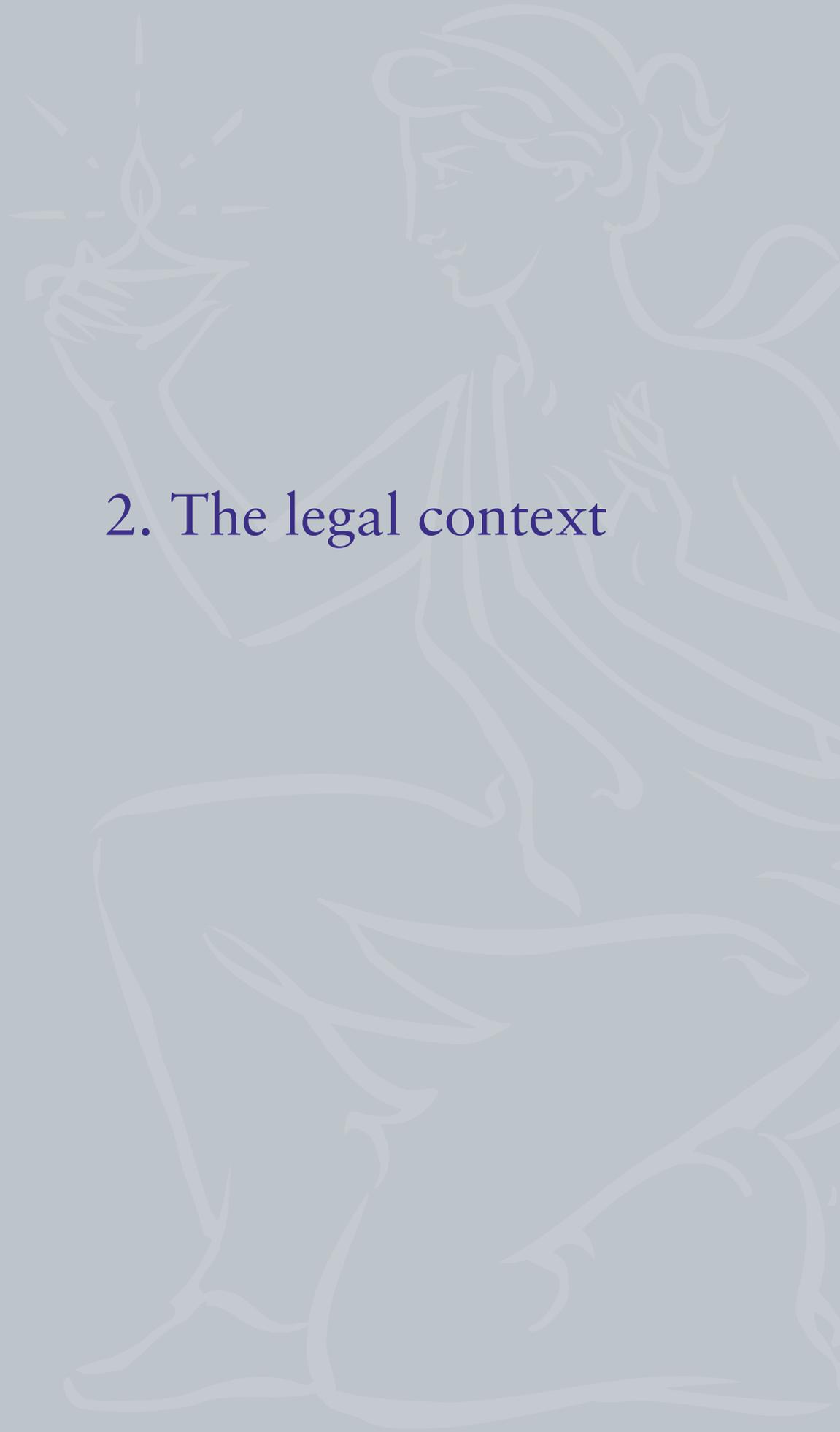
INTRODUCTION

1. Introduction

- 1.1 This document sets out to inform and support psychologists to make informed, sound clinical judgements and decisions across a range of sometimes very different situations where a client's capacity to make their own decisions is being questioned. Often, MCA assessments will be straightforward but there are examples across both health and social care situations where the questions and issues are complex.
- 1.2 This document updates previous guidance published in April 2006: *Assessment of Capacity in Adults: Interim Guidance for Psychologists*. At that time, the Mental Capacity Act 2005 (covering England and Wales) had recently received royal assent, being implemented from 2007 assisted by the Code of Practice published the same year. (Deprivation of Liberty Standards were also included via the Mental Health Act 2007.) The Adults with Incapacity (Scotland) Act received royal assent in May 2000. In Northern Ireland, recent legislation has resulted in the Mental Capacity Act (Northern Ireland) 2016 which recognises the interface between mental capacity and mental health assessments as well as incorporating criminal justice provisions. In England & Wales on 1 December, the Court of Protection (2017) rules and accompanying Practice Directions came into force.
- 1.3 Individual jurisdictions may require tailored, local guidance in terms of the development of case law. This document sets out broad principles covering best practice that are applicable across all jurisdictions. It relates to individuals aged 16 years and over. Throughout this document, where case law or legislation is quoted 'P' refers to the individual being assessed.
- 1.4 This document is the culmination of a consensus which has developed since the implementation of the MCA 2005 in England and Wales, itself drawing on Scottish experiences, including clinical practice and experience, research studies and case law.
- 1.5 The document's structure follows the chronological flow of a considered approach to assessment. It starts with an overview of the current legal context, followed by necessary preparatory steps and aspects of completing a best practice assessment (including consideration of the use of psychometric inventories) before drawing together the threads of information collected and forming defensible, balanced, well evidenced opinions, conclusions and recommendations.
- 1.6 MCA assessments are individual and, whilst common themes can be identified as helpful guidance, each case must be determined on its individual facts. Case examples are illustrative only and further examples will be available on the Society website. Following the principles set out in this document will provide psychologists with both direction and guidance as to how to complete good practice assessments as well as enabling confidence in decision-making which is appropriate, proportionate, fair and balanced.
- 1.7 Existing guidelines which psychologists should be aware of in terms of general good practice and professional responsibilities include, but are not limited to:
- a. BPS Practice Guidelines.
 - b. HCPC: Standards of Proficiency for Practitioner Psychologists.
 - c. HCPC: Standards of Conduct, Performance and Ethics.

- 1.8 All HCPC registered psychologists can complete MCA assessments. Psychologists should be mindful of their individual experience and knowledge, ensuring they act within their competencies as well as within codes of conduct at all times. Although MCA assessments require additional considerations and, often, knowledge, psychologists have skills that are also relevant to MCA assessments. Psychologists are aware of the need for good data collection, transparent decision-making, acknowledging any limits of expertise related to the assessment process, and providing a balanced analysis.
- 1.9 The Mental Capacity Advisory Group recognises particular complexity around decisions relating to sexual relations and intimacy which is addressed in a separate document (Capacity to Consent to Sexual Relations, 2019).
- 1.10 The field of mental capacity remains complex and subject to further review. The Mental Capacity Amendment Bill is going through parliament at the time of writing which will have an effect on legislation and practice in relation to Deprivation of Liberty Safeguards (DoLS).

2. The legal context



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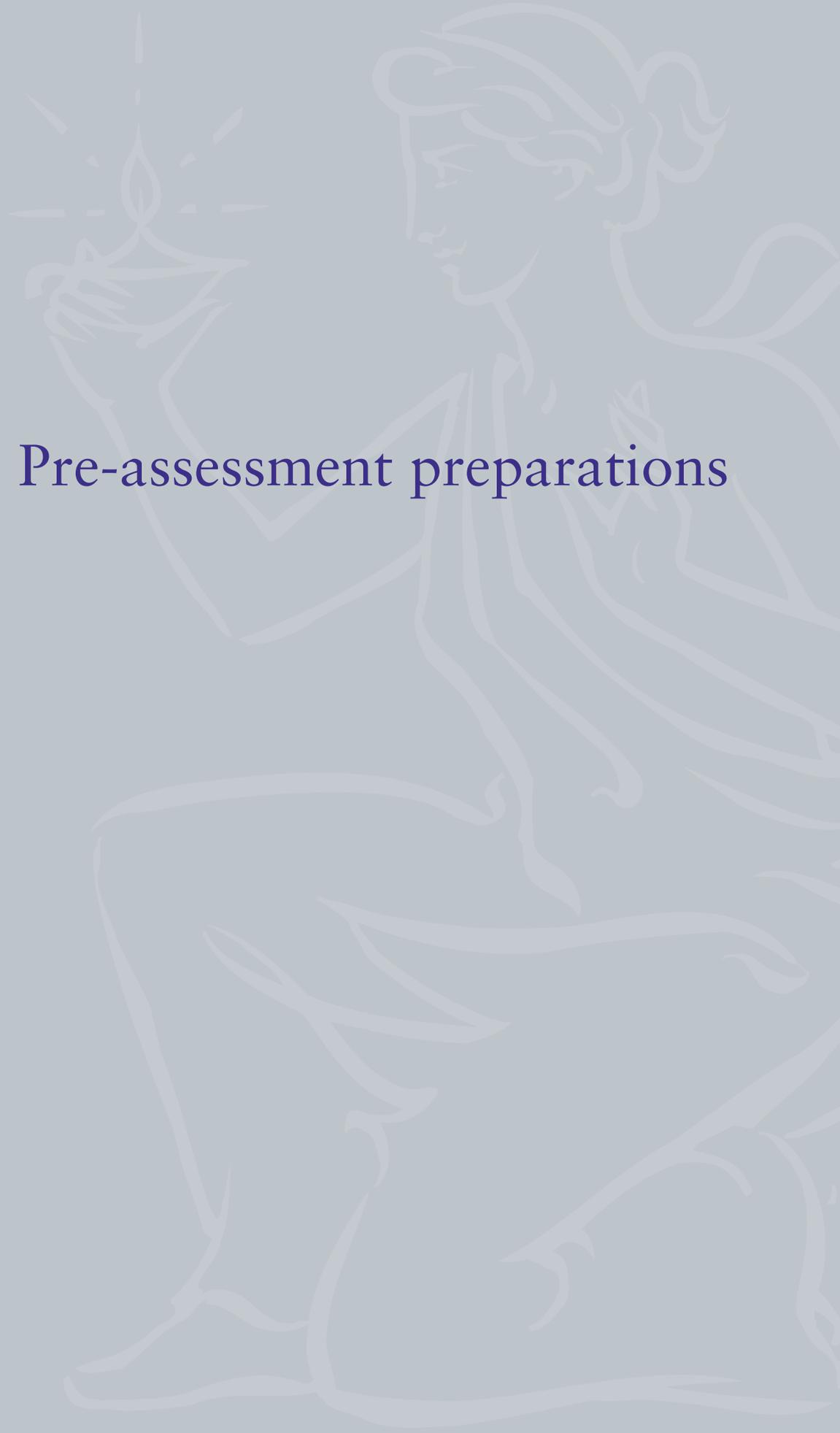
- 2.1 A person's ability to make decisions for themselves is particularly pertinent when these decisions affect their rights over where to live, whether and with whom to engage in sexual relations, consent to or refusal of medical treatment and testamentary decisions. Acknowledging the flaws of human beings, the right to make unwise and even life threatening decisions has also been upheld and protected in law.
- 2.2 There is also a history of these important life decisions being made on behalf of others, mainly within what was seen as paternalistic interventions (epitomised within the field of those with intellectual impairments and/or individuals suffering from serious mental illness) or where this was necessary (as for those suffering acute or chronic physical conditions affecting consciousness).
- 2.3 The legal framework in England and Wales is clearly set out within the MCA 2005 and summarised within the Code of Practice 2017. The five statutory principles are now well established across all jurisdictions:
- a. A person must be assumed to have capacity unless it is established that they lack capacity.
 - b. 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.
 - c. A person is not to be treated as unable to make a decision merely because they make an unwise decision.
 - d. An act done, or decision made, under the Act for or on behalf of a person who lacks capacity must be done, or made, in their best interests.
 - e. 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.
- 2.4 These principles aim to protect individuals' rights and help them to have as much input as possible into decisions that will affect them. The Court of Protection (2017) rules strengthen this principle of assisting P to be more involved in processes about him/her as much as they are able. All reasonable efforts must be made to help individuals make decisions including ensuring they have all necessary information provided in an appropriate format, with appropriate advice and support, and have had time to process this; help with communicating their decision may also be required. Location, timing and the process of the assessment are therefore all relevant. In emergency situations, immediate decisions may need to be made but always under the rubric of the individual's best interests.
- 2.5 A person lacks capacity in relation to a matter if, at the material time, they are unable to make a decision for themselves in relation to the matter because of an impairment of, or disturbance in, the functioning of the mind or brain. A decision regarding capacity cannot be made simply on a person's age, appearance, assumptions about their condition or any aspect of their behaviour (e.g. overt mannerisms or avoiding eye contact).
- 2.6 The MCA requires a two stage test in the assessment of capacity:

- i. The diagnostic arm determines whether there is an impairment of mind or brain.
 - ii. The functional arm determines whether the person has the capacity to make a particular decision.
- 2.7 It is important to be aware that the diagnostic arm of the test does not equate to a necessity to make a formal diagnosis of a particular disorder. Where there may be ambiguity about whether symptoms or criteria fall within the remit of the MCA, this will require additional discussion within the clinical team or, if within the court arena, a ruling by the court. It is important to ensure that decisions and their rationale are clearly set out so the decision-making process is clear. The document, *A Brief Guide to Carrying out Capacity Assessments* (November 2017) published by Essex Street Chambers is a useful guide.
- 2.8 Capacity relates to a specific decision (*PC v City of York Council [2014] 2 WLR 1 at [35]*) at a specific time (*CC v KK & STCC [2012] EWCOP 2136 per Bajer J at [20]*). Evidence of lack of capacity in one area cannot be used to determine capacity in another area, and neither does it relate to ability to make decisions generally (*Kings college Hospitals Foundation Trust v C [2015] EWCOP 80 per MacDonald at [26]*). Assessors should be mindful of not over-generalising findings e.g. inability to make complex financial decisions should not prevent a person maintaining choice over simple, daily purchases.
- 2.9 A functional test approach is used to assess capacity as required by the Act, whereby an individual is deemed incapable to make a specific decision if any of the following criteria are met (it is not necessary for all conditions to be met):
 - a. The individual is unable to understand information about the decision to be made (referred to in the Act as ‘relevant information’) i.e. the nature of the decision, the reason why it is needed and the likely outcomes of determining one way or another. A person does not need to know everything, only the salient details (*LBL v RYJ [2010] EWHC 2664 (fam) Macur J at [24 & 58]*).
 - b. The individual is unable to retain the relevant information for long enough even with the assistance of visual or other aids as required. Information need not be retained for long, only long enough to apply the information to the decision.
 - c. The individual is unable to use that information as part of a decision-making process i.e. an ability to use and weigh relevant information in order to come to a decision. This has been described as an ability to engage with the decision-making process and know how various parts of the decision relate one to another (*PCT v P, AH and the Local Authority [2009] COPLR Con Vol 956 per Hedley J at [35]*). Again, it is only necessary to be able to weigh the salient information (*CC v KK & STCC [2012] EWHC 2136 (COP) per Baker J at [69]*). This must be differentiated from an individual weighing information and still coming to what others consider to be an unwise decision; a person should be able to make the same mistakes as others (*R v Cooper [2009] 1 WLR 1786 at [13]*). (See also paragraph 2.12, page 4.).
 - d. The individual is unable to communicate their decision by whatever means.

- 2.10 It is important to consider that any identified limitation in capacity *must be because of* the identified impairment in the mind or the brain, thus establishing a direct causal nexus between the diagnostic and functional arms of the capacity test. If a client does exhibit deficits in any of the above areas but this is attributable to another cause, this must be stated or, equally, if the causation is multiply determined, this too needs stipulating so it is clear on what basis decisions about capacity are made.
- 2.11 It is important to bear in mind that any of the above limitations must be after sufficient attempts have been made to assist the individual in meeting the criteria if initial deficits are identified. For guidance on practical solutions to assist with increasing capacity see Appendix B.
- 2.12 If identified as present, loss of capacity should be stipulated whether it is partial or total, temporary or permanent or likely to fluctuate over time.
- 2.13 Whereas there is a presumption of capacity unless a concern is raised (described as a ‘reasonable belief’), decisions regarding lack of capacity are on the balance of probabilities. Within Court proceedings, the burden of proof rests with the party raising P’s possible incapacity. It is not for P to prove they are capable.
- 2.14 There are some differences of legal opinion in relation to the client’s ability to use and weigh information as part of a decision-making process and whether this should be read as conjunctive (the client needs to demonstrate both an ability to use and to weigh) or disjunctive (they only need to demonstrate either an ability to use or to weigh information). The current position of the Official Solicitor is that it is conjunctive¹ i.e. unable to use and weigh the information, although a number of eminent legal practitioners have also argued for a disjunctive use and, therefore, best practice would indicate that the psychologist have this distinction in mind when assessing this arm of the test and, if the client is found able in relation to one of the two aspects only, to state this within their report so the position is clear and third parties can make informed decisions.
- 2.15 Psychologists are not expected to be experts in the law, however, good practice indicates they should be familiar with case law relevant to the area(s) being assessed. For example, *Banks v Goodfellow (1870)* is still relevant for what reasonable information an individual needs to know to be capacitous to make a will, whilst *Masterman-Lister v Brutton & Co and Jewell & Home Counties Dairies [2003]* relates to capacity to litigate. However, there is not relevant case law in all areas where capacity to make decisions requires testing and, in these situations, it is useful for reports to set out what information has been considered relevant and necessary in each particular area in order to ensure open and transparent reporting.
- 2.16 This document cannot identify all relevant case law and psychologists must bear in mind their professional responsibility to have a sufficient knowledge of the relevant areas where they have agreed to undertake a MCA assessment. Useful online resources exist which psychologists may find useful such as www.mentalhealthlaw.co.uk

¹ *Use or Weigh? Or Use and Weigh? A response by Alasdair Pitbaldo, the Official Solicitor to the courts, 39 Essex Chambers, Mental Capacity Law Newsletter, February 2016, p12. See also: Kings College Hospital NHS Foundation Trust v C and V [2015] EWCOP 80, as per MacDonald J, para. 35*

3. Pre-assessment preparations

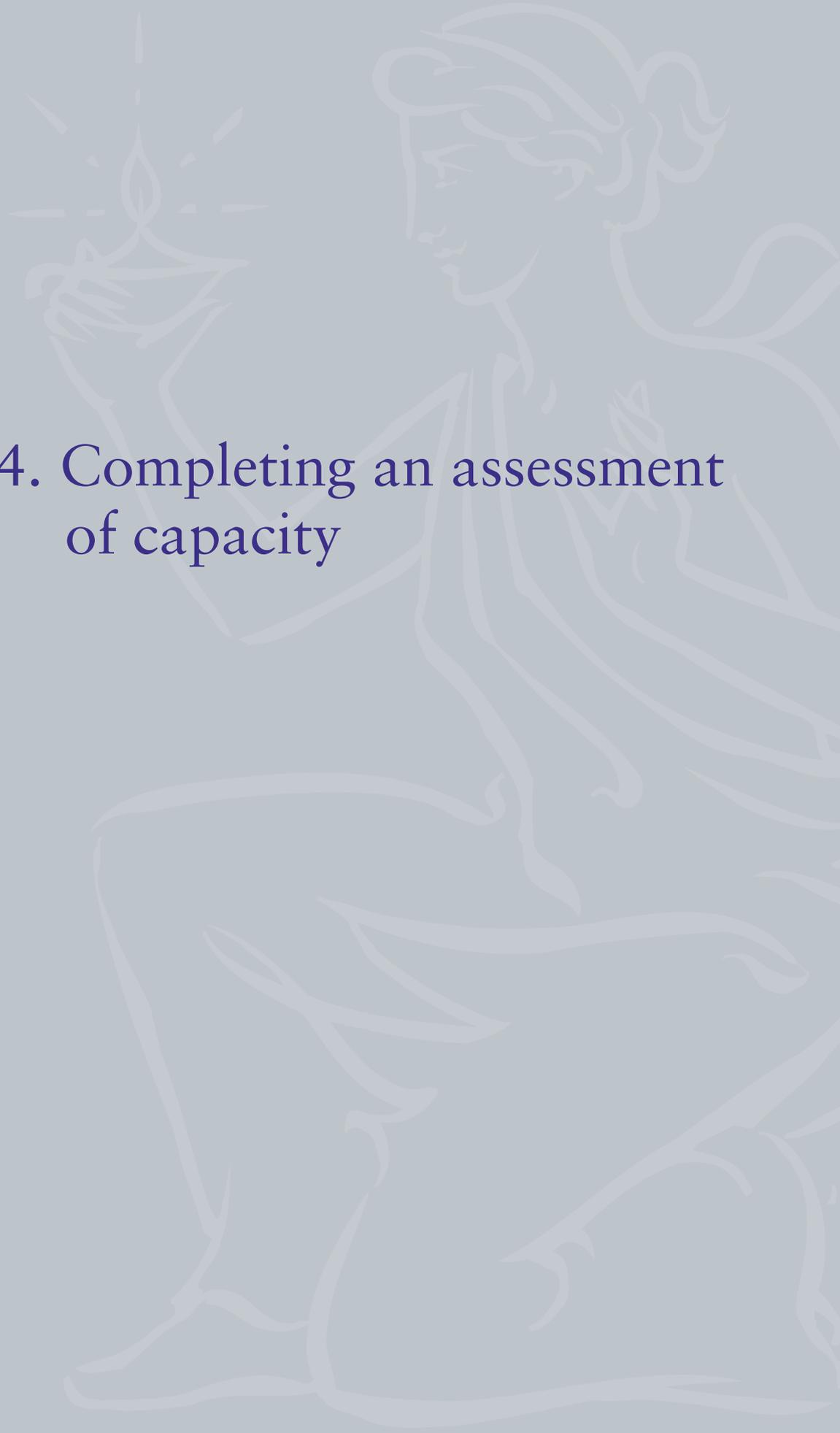


3. Pre-assessment preparations

- 3.1 A good assessment starts at the preparatory stage before meeting the client. This section addresses which areas psychologists should consider in advance, laying the foundations for a considered, appropriate and relevant assessment of capacity given that each case is different.
- 3.2 Psychologists should ensure they are clear exactly what is being asked in relation to capacity. This includes, but is not limited to, the following considerations:
- a. Who the client is and who is to be assessed?
 - b. What capacity assessment is actually being sought i.e. in relation to which areas of functioning and decision-making?
 - c. Why has capacity been raised i.e. what behaviours or evidence has been produced to question the individual's capacity?
 - d. What prior information is needed including what the potential identified difficulties are and what psychological and/or physical conditions may be present which will affect the assessment process?
 - e. Is all of the relevant information available in order to make an informed decision i.e. if capacity relates to testamentary capacity are the client's assets known?
 - f. Is there case law setting out guidance for individual areas of what constitutes relevant information in any one area?
 - g. What are the circumstances under which the assessment is being sought, including whether or not a previous assessment of capacity has been completed and, if so, relating to which issue(s)?
 - h. Does anybody, other than the client, need to be involved in the assessment including other professionals and/or family and others close to the client?
 - i. Are there any abusive or coercive elements present which may be influencing the client and which therefore need to be considered when assessing the client's capacity?
- 3.3 A preparatory meeting may be beneficial, particularly in complex cases, to introduce yourself to the client and to explain the overall process. Where available and appropriate, meetings with professionals or other key family members or friends who know the client well can assist with the early identification of factors that may hinder the assessment, so these can be off-set through appropriate considerations.
- 3.4 The interface between the MCA and the Mental Health Act 2007 (MHA) is complex and not always straightforward and psychologists should also consider whether what is being requested does fall within the scope of the MCA and not under an alternative legislative framework, such as the MHA.

COMPLETING AN ASSESSMENT OF CAPACITY

4. Completing an assessment of capacity



4. Completing an assessment of capacity

- 4.1 This section sets out guidance on completing a proportionate and appropriate MCA assessment. The assessor should be aware of the core case law which relates to the area of capacity being assessed. Whilst psychologists are not expected to be legal experts, initial research can be exceedingly helpful in clarifying exactly what information a client needs to have and to what level in order to be determined capacitous.
- 4.2 Online resources can assist e.g. www.mentalhealthlaw.co.uk. Where no case law exists, the lack of clarity regarding the key areas needs to be discussed within the report. It is good practice to set out what information has been considered necessary for any one area and some rationale as to why so that any future professionals reading the report are clear on what basis decisions have been reached. This document also provides a checklist (section 6) to aid with the assessment process.

CLINICAL INTERVIEWING AND NOTE TAKING

- 4.3 MCA assessments require particular attention to factors that influence a client's ability to make decisions and, therefore, their capacity within the meaning of the Act. In addition to general good practice in interviewing clients, further specific considerations must be made, which will vary across situations and individuals, dependent upon the suspected or identified deficits of the client. Other factors can affect a person's behaviour but may not be directly attributable to the first part of the test (the impairment in the functioning of the mind or the brain) and they must therefore be identified and, where possible, managed to reduce their influence. These include:
- interviewing the client at a time of day and in a location most conducive to their physical and/or psychological needs,
 - ensuring the length of appointments reflects the client's ability to remain attentive and shorter, but more frequent sessions, may be required,
 - identifying whether the presence of third parties assists or detracts from the client's ability to engage with the assessment and,
 - ensuring communication is appropriate to the client's level of understanding and assists with any identified deficits e.g. using British Sign Language,
 - ensuring any sensory needs by client are also addressed.
- For guidance on practical solutions to assist with increasing capacity see Appendix B.
- 4.4 The interview process should also consider the style and flow of questions and answers including how questions are phrased and put to clients to avoid compliance and overly-simplistic responses (i.e. simple yes or no answers) or leading questions which inhibit the client being able to fully demonstrate their actual knowledge and awareness level. For example, simply asking a client if they understand something is insufficient; instead, their understanding should be illustrated by a discussion of the matter under consideration, with questions and prompts as required to ensure all areas are covered.
- 4.5 Straightforward MCA assessments, covering simplistic matters (such as whether to provide a blood sample) can

be completed relatively quickly and in a single session.

- 4.6 Psychologists must ensure that sufficient time is allocated to complex assessments, particularly where clients may be difficult to engage and/or where there are multiple issues to discuss. Sufficient time must be allowed to explore the areas thoroughly with the client, allowing them time and opportunity to demonstrate their capacity (where they are able to do so), within the context of an appropriate relationship being made (where this does not already exist) and where contrary information obtained can be clarified and tested out with the client. It is best practice to complete an assessment over two sessions to give the client time to process and consider information discussed; this time also gives the assessor time to reflect and determine where to focus attention to clarify matters relating to capacity at the next session. Multiple sessions may not always be possible or feasible but should be aimed for.
- 4.7 Robust decision-making, particularly in complex areas, requires robust data collection with information gathered from multiple sources where possible. What information is required will vary depending upon the matter under consideration but it is important to seek, where possible, additional evidence to support or negate the client's direct communications through third parties familiar with the client or other written documentation. It is unwise to rely totally on direct accounts from the client; where this is unavoidable due to external constraints, this limitation should be described and any potential impact on the outcome explained in the report.
- 4.8 In most MCA assessments, it will be beneficial to include relevant third

parties within the overall assessment of capacity to provide broader information and examples of either where capacity is evident or where it is not. Relevant information to be obtained from third parties will vary considerably dependent on the nature of the relationships and the overall context but the following are generic guidelines:

- General feedback of the client's usual presentation and overall situation relating to their living environment, daily living skills and level of independent functioning and any support needs.
 - Information supporting or negating the diagnostic part of the test i.e. an impairment in the functioning of the mind or the brain.
 - Examples related to each of the functional arms of the test in terms of the client's ability to recall information and use and weigh it when considering their options.
 - Advice regarding any additional factors that may influence capacity such as mood.
- 4.9 Case law (*WBC v Z [2016] EWCOP 4*) has highlighted the limitations of capacity reports based on collations of discussions with clients; the judgement set out why verbatim quotes are more beneficial in providing third parties (in this case the Court of Protection) with a more nuanced, detailed and individual picture of exactly why a client has or lacks capacity. Therefore, as good practice within all capacity assessments, psychologists should consider making clear records of their assessment including, but not limited to, the following:
- When interviews were conducted: date, venue, start and finish times.
 - Who was present at each interview.
 - Impressions of how the client presented e.g. level of alertness, attention, mood etc.

- Efforts made to improve the client’s capacity e.g. making appointments at the best time of day and language used and their response to this.
- Verbatim responses by the client to specific questions directly related to the area of capacity under consideration.

4.10 These specific examples and high level of detail can underpin conclusions reached, offering transparency and a more rigorous approach to assessment.

4.11 To practising psychologists, issues such as personal bias or sub-conscious factors influencing decision-making are already well known and supervision and reflection are important tools to help counter these. Mental Capacity Act assessments require this too as personal biases may impact on how individuals or

a decision is approached, or may cause emotional reactions to the case itself. Finally, psychologists should be open to multiple points of view and a transparent decision making process.

4.12 Psychologists should also consider extraneous variables which, if present, may affect the client’s behaviour and responses but which are not attributable to any identified impairment in their mind or brain and which may give a false impression of their capacity. Therefore, psychological issues such as mood, social and communication skills, shyness, lack of confidence and under-assertiveness, suggestibility and deference to authority should be noted within the report if present (and any impact) and techniques employed to limit their influence.

AWARENESS OF CONTEXT

4.13 Psychologists will be asked to conduct MCA assessments in a variety of contexts and situations. As these will be highly variable, this document sets out important issues to be aware of in completing individual Capacity Act assessments as context may influence not only the practitioner’s approach but also, potentially, third parties’ inputs too.

4.14 Broadly speaking, MCA assessments will fall into three main contexts:

- those completed within legal structures usually within the Court of Protection,
- complex decision-making requirements within clinical teams and
- those occurring routinely within daily practice.

As the last context is straightforward and can easily be subsumed within these guidelines, this document will focus on the first two considerations in more detail.

Legal contexts

4.15 Looking first at the former, there is some clarity when completing MCA assessments within a legal context, as well as some challenges. The legal structure of court proceedings provides the psychologist with a clear framework of what exactly is requested,

by and for whom and by when. Legal representation of all parties offers a level of confidence in the maintenance of boundaries, protection of the clients’ (and psychologists’) rights and clarity on parties’ responsibilities (including the assessing psychologist’s). Instruction

by a legal representative may also set out relevant case law, which assists the psychologist in identifying the necessary information which the client should know in order to be deemed capacitous and which, therefore, helps determine the parameters, as well as the content, of the assessment. If instructions are not clear or necessary case law is omitted, these should be clarified with the instructing solicitor at any early stage. Legal proceedings may also bring access to useful medical records or other important documents.

4.16 Challenges of conducting MCA assessments within legal proceedings often relate to restricted timeframes. Psychologists should be aware how this may impact on the quality of the assessment and raise any concerns at an early stage, clearly setting out how this may impact on what can reasonably be achieved. Restricted timeframes are not a reasonable excuse for a poorly informed assessment and any limitations should be clearly set out within the report.

Clinical contexts

4.17 Psychologists should be aware of wider dynamics and implicit influences when approaching MCA assessments of clients within statutory systems, including within both health and social care. Both systems can create contexts in which paternalistic attitudes may still dominate and where clients find themselves disempowered by their diagnoses or overall situation. In forensic and criminal justice situations, whilst disempowerment is present, so too can be punitive judgements and mutual mistrust, both of the client by the system and of the assessor by the individual client. Any and all of these factors can influence how clients engage in assessments and how they are seen by those treating and/or assessing them, yet do not directly relate to an individual's capacity to make decisions

based on any impairment in the functioning of their mind or brain. The psychologist's duty is to be aware of potential extraneous factors and try to overcome them, consider their influence in the individual case and record, as necessary, what impact they have had, if any, on the process and outcome.

4.18 Completing specific MCA assessments can affect the working relationship between a client and the professional and this also needs to be considered as to who is best placed to complete an assessment in any one situation. However, MCA assessments completed within clinical settings also has the benefit of multiple input and perspectives including across different areas of a client's functioning such as mental health, sensory needs etc.

WORKING INDEPENDENTLY VERSUS BEING PART OF A TEAM

4.19 There are benefits and challenges to completing MCA assessments within teams, including jointly with other professionals. Considerations here include the nature of any pre-existing relationship between the psychologist and client being assessed as noted above. A pre-existing relationship

confers greater knowledge of the client and their general abilities as well as the client likely feeling comfortable and at ease with the psychologist. However, any therapeutic alliance may also bias the assessor's view of the client's competencies and/or influence them in a particular direction in order

to protect the working relationship. Clear boundaries are also required for the client in order to differentiate this specific assessment from other areas of intervention.

- 4.20 Completing capacity assessments as part of a team can confer benefits in terms of wider knowledge and experience of the client across multiple timeframes and possibly different situations, giving greater confidence that the conclusions reached are grounded in solid evidence. However, multiple professionals with different experiences of the client and variable knowledge of specific Mental Capacity Act assessments are more likely to lead to disagreement, sometimes significantly so. In such situations, the initial step is to clarify areas of agreement and outstanding areas of disagreement. For these areas, it will be necessary to review what is required to meet the capacity threshold and then, against this, methodically discuss the evidence, again highlighting areas of agreement and disagreement. If agreement still cannot be reached, teams may have a number of options:
- an individual member of staff may

be considered to have the final say, although good practice would dictate that differences of opinion are still recorded;

- an external professional may be available whose role is to consider the evidence set out and either make the final decision or assist the team with their own process;
- legal process may need to be invoked where disagreement is fundamental and agreement cannot be reached.

- 4.21 Making complex decisions, which can have far-reaching consequences for clients, is often difficult and intellectually, morally and emotionally challenging. Forming an opinion about capacity is a subjective process and it isn't unusual for professionals to disagree where issues are complex and not always easily measured or defined. If any professional feels particularly concerned about decisions reached, supervision may assist to help them process what exactly has been challenging and how to resolve it for themselves.

USE OF PSYCHOMETRIC INVENTORIES

- 4.22 Psychometric inventories can be a useful part of a psychologist's professional repertoire and many will consider them when conducting MCA assessments. It is important to state *there is no psychometric inventory designed to measure capacity within the meaning of the Act and it therefore follows that an individual's capacity cannot be determined based on test results alone.*
- 4.23 However, psychometric inventories can provide useful, informative data which assists the practitioner to come to an opinion regarding one or more elements of an individual's ability to meet the individual requirements of the functional

test (see page 10, para 2.7). Areas to be assessed might include: general intellectual ability, memory and ability to learn, attention and concentration, verbal comprehension and expression, reasoning, information processing and executive functioning. Consideration should also be given to the use of appropriate tests of effort when using psychometric assessment. A profile of an individual's strengths and weaknesses can be useful in determining their functioning in relation to some arms of the test such as memory and ability to recall information generally (providing a context for a more focused

assessment of recall of specific, relevant information) or an assessment of executive functioning for an individual's ability to use and weigh relevant information as part of a decision-making process. Executive functioning is difficult to formally assess. However, tests can indicate ability to plan, organise, follow instructions, adhere to and switch between rules as well as initiate and inhibit responses.

- 4.24 Psychometric inventories may also be used as part of the assessment regarding the first arm of the capacity test i.e. the existence of an impairment in the functioning of the mind or brain and to what extent. The clearest example here is a current assessment of intellectual functioning as part of determining the presence (or otherwise) of a globalised learning disability.
- 4.25 Finally, data from psychometric inventories may help guide the psychologist in how best to interview the client if specific deficits or limitations are identified early on and how to enhance their capacity. This may relate

to intellectual or working memory deficits as well as broader issues relating to mood which may impact on how an individual presents and responds to questions, and which may also impact on current capacity issues. If specific cognitive difficulties are identified, such as slowed speed of information processing, capacity can be enhanced by compensating for such difficulties when assessing an individual's capacity to make the specific decision in question.

- 4.26 The BPS' Psychological Testing Centre can answer any queries relating to individual tests. Psychologists are reminded of the importance of maintaining up-to-date information on tests and their development and to use the most recent version of inventories. The Psychological Testing Centre offers useful information on core qualities of approved tests such as their reliability and validity, as well as using tests with appropriate standardisation samples and, therefore, their overall clinical utility and relevance in any one given case.

BEST PRACTICE IN DRAWING TOGETHER CONCLUSIONS, OPINIONS AND RECOMMENDATIONS

- 4.27 Forming valid, defensible conclusions can be difficult, particularly when there is a lot of information to consider. How to balance sometimes disparate information can be challenging and, where required, supervision or team discussions can help judge the strength of each piece of information and, therefore, ultimately, the final weight given to it within the overall analysis. Similarly, although there is case law and therefore guidance in relation to some areas, this is not available in all and there remain grey areas of how much information a client needs to know to be deemed capacitous. Practitioners should be aware the assessment provides an

opinion on the balance of probabilities and the outcome may ultimately be determined by the Court of Protection. Nevertheless the process will be assisted by referring back to the specific parameters of the capacity assessment being undertaken alongside the use of a methodical, balanced analysis of each step of the functional test and a clear balancing of evidence which either indicates the client's ability or not for each arm of the test. The causal nexus between the deficit and identified impairment in the mind or brain must also be recorded.

- 4.28 Practitioners should revisit areas if it becomes apparent there is insufficient

information available or else state this lack of data within the report and its impact on the surety of the conclusions reached. It is more acceptable to have completed a comprehensive assessment yet still not have all the information to hand rather than be persuaded to go beyond the information available and come to conclusions which are not supported on the available evidence.

- 4.29 It is important to summarise what attempts have been made to assist capacity and their impact on the client's functioning and overall outcome. The report should also state whether incapacity in the identified area is permanent or temporary, or it may fluctuate in line with other medical or psychological conditions; if this is the case, guidance should be offered on prognosis and possible future course alongside consideration of when capacity should be re-assessed or reviewed. This may also need to take into account

proposed interventions to work with the client to improve their knowledge or skills, what this will involve and when capacity should be reassessed.

- 4.30 Capturing the client's wishes and values is important and these should be clearly set out as they can influence decision-making meetings based on the person's best interests and need to be taken into account.
- 4.31 The aim is to provide an assessment which is comprehensive, which follows best practice guidelines and which is evidence-based and not to determine an absolute truth of whether or not a client has capacity in any one case. Also, in many cases, the assessor may not be the ultimate decision maker in relation to a client's capacity but one part of a wider process, with the ultimate decision being taken by another person or body.

5. Equality considerations

- 5.1 Issues of equality and diversity are enshrined in law and, therefore, also in organisations' policies and procedures to ensure best practice and consideration of individuals' rights and needs. Psychologists should be aware of these issues within the broader context of treating each client as an individual, on their specific circumstances, and with their relevant history and presenting difficulties. Ensuring fairness and equality of opportunity means providing different interventions for each individual's needs, whilst including these considerations within the overall formulation and analysis.

Appendix A – Mental Capacity Assessment Checklist

A. Before starting the assessment

QUESTION	TASKS/ADVISORY NOTES	REFERENCE/ FURTHER GUIDANCE
<p>A1. Does the person have a disorder of mind or brain?</p>	<ul style="list-style-type: none"> Establish what disorder of mind or brain the person is suffering from and whether this could reasonably be affecting the person’s decision-making at the material time the decision is required to be made (e.g. learning disability, acquired brain injury, neurodegenerative disorder, and/or mental health disorder). Is the disorder of mind or brain temporary or permanent? If temporary consider whether the decision in question can be delayed until the person regains mental capacity. NOTE: You do not need to diagnose a specific disorder in order to apply the MCA; however, it should be clear that the person is experiencing some difficulties with functioning of their mind or brain (e.g. problems with memory, decision-making, or communication). Also, consider whether the MCA is the most appropriate legislation to be using or is another act more relevant? <p>For instance:</p> <p>a) Mental Health Act (1983, amended 2007):</p> <ul style="list-style-type: none"> Should be used instead of the MCA if ‘appropriate medical treatment’ is available for the disorder of mind, and treatment would ‘alleviate, or prevent a worsening of the disorder or one or more of its symptoms or manifestations’. ‘Medical treatment’ includes ‘psychological intervention and specialist mental health habilitation, rehabilitation and care’. A person can be detained for treatment ‘in the interests of his own safety or with a view to the protection of other persons’. 	<p>MCA Section 2 (p.2). MCACoP (p.41).</p> <p>BPS (2019). <i>What makes a good assessment of capacity?</i> (Section 2).</p> <p>Mental Health Act amendment (2007) Part 1, Chapter 1, section 4 and 7.</p> <p>Mental Health Act 1983, Part II, Section 2(b).</p>

QUESTION	TASKS/ADVISORY NOTES	REFERENCE/ FURTHER GUIDANCE
<p>A1. Does the person have a disorder of mind or brain? (Continued)</p>	<p>b) Care Act (2014):</p> <ul style="list-style-type: none"> Safeguarding legislation should be used if there are concerns that a vulnerable adult may be at risk of harm (through abuse, neglect or exploitation). This legislation can be utilised to help manage risk of harm in vulnerable people who are deemed capacitous to make unwise decisions. 	<p>Care Act 2014 p.39 (44, 1).</p>
<p>A2. What is the specific decision that is being assessed?</p>	<ul style="list-style-type: none"> Define the question in clear terms (e.g. <i>‘Does X have the mental capacity to decide where to live on discharge from hospital?’</i>). If there are multiple aspects to the assessment, break them down into individual questions. For instance, X may need to understand his financial circumstances to be able to make a decision about where to live, therefore there may be two capacity questions: <ol style="list-style-type: none"> Capacity to manage financial affairs. Capacity to make a decision about residency. Use, list, and describe formal tests (i.e. as defined in case law) that are relevant to the specific capacity question? (e.g. Common Law tests exist for making a will, making a gift, entering into a contract, marriage, and capacity to litigate). 	<p>MCACoP Chapter 4.32 (p.51). BMA/Law Society.</p> <p>BPS (2019) <i>What makes a good assessment of Capacity?</i> (Sections 3 & 4).</p> <p>www.mentalhealthlaw.co.uk</p>
<p>A3. Has the expected level of knowledge required to understand the information relevant to the decision been stipulated in advance?</p>	<p>The assessment should be made against clear criteria for the expected level of knowledge/ decision making required to demonstrate the required capacity.</p> <p>Decide what information is relevant to the decision and interview relevant parties so you have this information in advance of the assessment. For instance, in order to assess capacity to manage financial affairs you would need to have specific information about the person’s assets (i.e. total annual income, property, etc.) and outgoings (i.e. total cost of bills and the payment schedule).</p>	<p>Relevant professional practice and NICE guidelines (see reference list)</p> <p>Case law for the specific decision and/ or empirical literature regarding professional practice guidelines.</p> <p>For example:</p> <ul style="list-style-type: none"> Consent to treatment, Roth et al. (1977); Searight & Hubbard (1998). Advanced directives, Molloy et al. Health Proxy, Mezey et al. (2000)

QUESTION	TASKS/ADVISORY NOTES	REFERENCE/ FURTHER GUIDANCE
A4. Is it clear why capacity was questioned for this specific decision?	Remember the MCA stipulates that the person is assumed to have capacity unless there is reason to doubt this. Ensure you have clear evidence for doubting the person's capacity. If not, seek clarification from referrer before proceeding.	MCACoP Chapter 4.34 – 4.36 (p.52). BPS (2019) <i>What makes a good assessment of capacity?</i> (Section 2)
A5. Are the circumstances and rationale for the assessment clear?	Set the scene for the assessment and identify any limitations to the assessment, or the assessment context (e.g. setting, time constraints, information available) that may directly or indirectly influence the opinion reached.	Relevant professional guidance. BPS (2019) <i>What makes a good assessment of capacity?</i> (Sections 3 & 4).
A6. Is it clear who the actual decision holder is?	The MCA stipulates that the 'decision holder' is ultimately responsible for making the decision about someone's mental capacity but they can consult a professional for advice on the matter. Establish who is responsible for making the decision (e.g. If the specific question relates to a person's capacity to consent to treatment: '... ultimately, it is up to the professional responsible for the person's treatment to make sure that capacity has been assessed'. So in this context it might be the medical consultant but they may defer to the psychologist for their opinion or advice.	MCACoP Chapter 4.40 (p.54). BPS (2019) <i>What makes a good assessment of capacity?</i> (Section 4).
A7. Do any of the exclusions apply (e.g. age, MHA, Advance Decisions)?	MCA exclusions: <ul style="list-style-type: none"> • MCA can only be applied to people aged 16 and over. • Mental Health Act generally supersedes the MCA (i.e. If the person has a mental health disorder and requires treatment in his/her best interests to prevent harm to self or others, then the decision should be taken to do this under the MHA, not as a best interest decision under the MCA). • MCA cannot be used to treat someone in his/her best interests if an Advance Decision has been stipulated in relation to the decision (e.g. if an Advanced Decision to refuse treatment exists; or if there is an alternative decision maker appointed such as a lasting power of attorney). 	MCA Part 1, Section 2(5) (p.2) and CoP Chapter 12 (p.216). MCA Part 1, Section 28 (p.17) and MCACoP Chapter 13 (p.225). Medico Legal MCA Part 1, Section 24–26 (pp.15–16) and MCACoP Chapter 9 (p.158).

QUESTION	TASKS/ADVISORY NOTES	REFERENCE/ FURTHER GUIDANCE
<p>A8. Do any exclusions apply to the best interests decision process?</p> <p>There are a number of decisions that cannot be taken on behalf of someone who lacks capacity, including marriage, sexual relations, and parenting.</p>	<p>Check that the instructions you have received do not ask you for an opinion about a person's best interests (BI) in relation to an excluded area of BI best decision-making, for example:</p> <ul style="list-style-type: none"> • Intimate personal relationships. • Voting. • Adoption or matters affecting the person's child. • Care or treatment authorised under the Mental Health Act. 	<p>MCA Part 1, Section 27–29 (pp.16–17) and 62 (p.35) and MCACoP Chapter 1.8-1.11 (pp.16–17).</p>
<p>A9. What is the best time and location to carry out the assessment?</p>	<p>Assessments of capacity only apply at the material time that the assessment is being conducted; therefore it is essential to select a time and length of session that gives the examinee the best chance of success. It might be necessary to schedule the assessment over multiple sessions to establish if there is any variability in responses over time and in different situations. The importance of these factors must be documented and explained in the report.</p>	<p>Relevant professional guidelines (see reference list).</p> <p>BPS (2019) <i>What makes a good assessment of capacity?</i> (Sections 3 & 4).</p>
<p>A10. Is there any aspect of the context that may affect the reliability or validity of the assessment?</p>	<p>For example, if the person is deaf, blind, aphasic, drowsy, or uncooperative; noisy public environment; limited time to carry out assessment; or presence of family members/staff who could influence the examinee's answers.</p>	<p>BPS (2019) <i>What makes a good assessment of capacity?</i> (Sections 3 & 4).</p>

B. Conducting the assessment

QUESTION	TASKS/ADVISORY NOTES	REFERENCE/ FURTHER GUIDANCE
<p>B1. The ‘diagnostic test’</p> <p>Does the person have an impairment of, or disturbance in the functioning of, mind or brain?</p>	<p>Consider what assessments or evidence you have that demonstrates that the person has an impairment of, or disturbance in the functioning of, mind or brain that may impacting on the person’s decision-making.</p> <p>Is the impairment of, or disturbance in the functioning of, mind or brain temporary or permanent.</p> <p>If necessary, formally assess the person’s communication ability, intellectual disability, neurological and cognitive functioning.</p> <p>Identify any emotional/mental illness aspects that might affect responses (e.g. anxiety, depression, psychosis, delusional beliefs).</p>	<p>MCA Part 1, Section 2(1) (p.2).</p> <p>MCACoP Chapter 4.11–4.12 (pp.44–45).</p> <p>Relevant professional practice guidelines (e.g. for cognitive assessments see AACN, practice guidelines, 2007; Moye, 1999; BPS DCP FPID (2015) <i>Guidance on the assessment and diagnosis of intellectual disabilities in adulthood</i>. BPS (2019). <i>What makes a good assessment of capacity?</i> (Section 4).</p>
<p>B2. Understand the relevant information in basic terms</p> <p>Has the expected level of knowledge required to understand the information relevant to the decision been presented to the examinee in advance?</p>	<p>Question the examinee about their understanding of the relevant information.</p> <p>If not, provide them with the information relevant to the decision.</p>	<p>Relevant professional practice guidelines (see reference list).</p> <p>MCACoP Chapter 4 (p.40) generally and Chapter 4.49 (p.58) & 4.52 (p.59).</p> <p>BPS (2006) <i>Assessment of capacity in adults: Interim guidance for psychologists</i>.</p> <p>BPS (2019). <i>What makes a good assessment of capacity?</i> (Sections 2.4, 2.7(a), and 4.26).</p>

QUESTION	TASKS/ADVISORY NOTES	REFERENCE/ FURTHER GUIDANCE
<p>B3. Does the examinee understand the purpose of the assessment?</p>	<p>Explain the MCA to the examinee in simple terms and state clearly and specifically the question to be answered.</p> <p>If there is more than one question, set out each specific decision to be subjected to the test of mental capacity.</p>	<p>Relevant professional practice guidelines (see reference list).</p>
<p>B4. Does the examinee understand why capacity is being questioned for this specific decision?</p>	<p>Set out the evidence that answers this question (e.g. referral information received, concerns raised, implications of being deemed not to have capacity for this decision versus having capacity).</p>	<p>MCACoP Chapter 4.34 – 4.36 (p.52-53).</p>
<p>B5. Does insight impact on the examinee’s ability to understand the information relevant to the decision and/or foreseeable consequences of the decision?</p>	<p>Where knowledge of impairments/disability is relevant to decision making ask questions that elicit whether the examinee understands their impairment/disorder of mind and medical opinion/evidence (i.e. risk assessments) about the impact of their condition on their abilities.</p>	<p>Relevant professional guidelines (see reference list).</p>
<p>B6. Retain the information long enough to make a decision The person must be able to hold the information in mind long enough to use it to make an effective decision</p>	<p>Assess whether the person demonstrated that they could retain the information relevant to the decision.</p> <p>Notes: MCA (2005) Section 3(3) states that people who can only retain information for a short while must not automatically be assumed to lack the capacity to decide – it depends on what is necessary for the decision in question.</p> <p>Items such as notebooks, photographs, posters, videos, and voice recorders can help people record and retain information.</p>	<p>MCACoP Chapter 4.20 (p.47).</p>

QUESTION	TASKS/ADVISORY NOTES	REFERENCE/ FURTHER GUIDANCE
<p>B7. Weigh information in the balance?</p> <p>Can the examinee identify, use and weigh risks and benefits for the specific issue?</p>	<p>Ask questions that require the examinee to illustrate their rationale for weighing pros and cons.</p> <p>Question the examinee about other people's perspectives (who might be affected by their decision-making) and their rationale for following or dismissing these views.</p> <p>If the examinee cannot reach a decision this demonstrates they cannot weigh information in the balance. If the examinee cannot apply their knowledge of risks and benefits to their own situation regarding the specific issue being assessed, then this would be evidence of being unable to use the information. That is, if the examinee can set out pros and cons in an abstract, hypothetical situation, but does not consider these to apply to their situation (e.g. due to lack of insight into an aspect of their cognitive, behavioural or psychological needs) then this would be evidence of being unable to use the information relevant to the decision.</p>	<p>MCACoP Chapter 4.21 (p.48) (Using or weighing information as part of the decision-making process) and Chapter 4.22 (p.48).</p> <p>Use or Weigh? Or Use and Weigh? A response by Alasdair Pitbaldo, the Official Solicitor to the courts, 39 Essex Chambers, Mental Capacity Law Newsletter, February 2016, p.12.</p> <p>See also: Kings College Hospital NHS Foundation Trust v C and V [2015] EWCoP 80, as per MacDonald J, para. 35.</p> <p>Relevant professional guidelines.</p>
<p>B8. Can the examinee weigh information in the balance at the material time the decision is required to be made?</p>	<p>It is important to consider any behavioural evidence (e.g. evidence from clinical notes and observations) that demonstrate that in the moment a decision needs to be taken the examinee does not act in accordance with his expressed wishes when interviewed. In other words, the examinee must be able to demonstrate making a decision in the real world, not just in the capacity interview. Note that individual instances of a person acting contrary to previous expressed opinion is unlikely to be sufficient to demonstrate a lack of capacity; however, a repeated pattern of doing so and being unable to reasonably account for this discrepancy when asked may do so.</p>	<p>Frontal lobe paradox (George & Gilbert, 2018).</p> <p>Case law: Cf. Loughlin vs. Singh [2013] EWHC 1641 (QB) MHLO 71.</p>

QUESTION	TASKS/ADVISORY NOTES	REFERENCE/ FURTHER GUIDANCE
<p>B9. Has the impact of religious/cultural beliefs and values been considered?</p>	<p>Collect background information from people or records.</p> <p>Ask questions to establish whether expressed beliefs and values pre- or post-date the impairment of mind. Beliefs that pre-date the impairment would be deemed capacitous, albeit unwise decision-making.</p> <p>Assessors should be particularly mindful that, where such beliefs and values conflict with their own, or are outside usual social norms, there is an increased risk of inappropriately deeming the person to lack capacity.</p>	<p>MCACoP Chapters 4 (p.40) and 16 (p.270) (Rules governing access to information).</p> <p>MCACoP Chapter 5 (p.63), 5.46 (83).</p> <p>BPS (2006) <i>Assessment of capacity in adults: Interim guidance for psychologists</i> Chapter 2 (p.23).</p> <p>BPS (2019). <i>What makes a good assessment of capacity?</i> (Sections 2.8-2.9).</p>
<p>B10. Have you included checks for consistency of responses?</p>	<p>If practicable, repeat assessment over multiple sessions and in different settings to test out consistency of response. This is especially important when the decision will need to be taken at multiple time points (e.g. decisions about financial management).</p>	<p>Relevant professional practice (see reference list).</p>
<p>B11. Was there any evidence of suggestibility/social influence in their responses?</p>	<p>If so, describe and provide evidence of how this was addressed and/or taken into account.</p>	<p>BPS (2006) <i>Assessment of capacity in adults: Interim guidance for psychologists</i>.</p> <p>BPS (2019) <i>What makes a good assessment of capacity?</i> (Section 4.4 and 4.12).</p> <p>Gudjonsson suggestibility scales (Polczyk et al., 2004)</p>
<p>B12. Communicate decision? Has a decision been clearly communicated?</p>	<p>Decisions can be communicated by any means possible (e.g. verbal or sign language, gesture, drawing, writing, etc.).</p>	<p>MCACoP.</p>

C. Enhancing capacity

QUESTION	TASKS/ADVISORY NOTES	REFERENCE/ FURTHER GUIDANCE
<p>C1. What consideration has been given to how capacity could be enhanced?</p>	<p>Attempts should be made to compensate for cognitive/communication/emotional disabilities by using support tools (e.g. if English not first language use interpreter; if receptive or expressive problems use communication support tools).</p>	<p>MCA, Part 1, Section 1 (3) The Principles (p.1). Part 1, Section 1 (6) (p.2). Part 1, Section 1(3) (p.1). MCACoP Introduction (p.1), Chapter 2.6 – 2.7 (p.22). BPS (2019). <i>What makes a good assessment of capacity?</i> (Appendix B). Relevant professional practice guidelines (see reference list).</p>
<p>G2. Has the person had sufficient time to assimilate issues that have arisen? Have psychological aspects of adjustment to change been taken into account in their responses?</p>	<p>Where possible, a decision should be delayed to enable the person to regain capacity. For instance, if the capacity question relates to residency and the person is currently an inpatient following a stroke, efforts should be made to enable the person to understand what returning home with his disability would be like (e.g. home visit and trial of micro-environment living). Similarly, the alternative options need to be clearly understood (e.g. visit to a care home or alternative residential environment).</p>	<p>MCACoP. BPS (2006) <i>Assessment of capacity in adults: Interim guidance for psychologists</i>. BPS (2019) <i>What makes a good assessment of capacity?</i> (Section 4.8, 4.9, 4.12 and 4.28).</p>
<p>C3. Is there evidence that the person could make the decision if given more time?</p>	<p>Consider whether there is any evidence that the person has shown new learning that might change the outcome with time. For instance, a person with severe disability who cannot communicate his decision currently but is learning to use a communication aid (e.g. eye gaze software) and it is suspected may be able to communicate a decision once the communication aid is established.</p>	<p>BPS (2006) <i>Assessment of capacity in adults: Interim guidance for psychologists</i>. BPS (2019) <i>What makes a good assessment of capacity?</i> (Section 2.10).</p>

D. Report writing

QUESTION	TASKS/ADVISORY NOTES	REFERENCE/ FURTHER GUIDANCE
<p>D1. Has information about the assessment process and content been clearly stated?</p>	<p>The following should be included:</p> <ul style="list-style-type: none"> • Date of report. • Name and title of assessor and organisation. • Place of assessment. • Name and title of decision holder, and/or who has requested the assessment. 	<p>Relevant professional practice guidelines (see reference list).</p>
<p>D2. Have you answered:</p> <p>a) Whether the person could understand the information relevant to the decision?</p>	<p>You must include sufficient explanation of capacity assessment findings that demonstrate:</p> <p>a) The examinee is either able or unable to understand the information relevant to the decision in basic terms.</p> <p>Note that the Court of Protection prefer to have verbatim responses recorded in the report, rather than a summary of the discussion. Assessors should keep sufficiently detailed notes from their dialogue with the person to evidence direct quotes, ideally taken during the assessment conversation to ensure accuracy.</p>	<p>MCA Part 1, Section 3(1) (a) (p.2).</p> <p>MCACoP Chapter 4 (p.40).</p> <p>Sullivan, 2004 (2-stage model defining what is relevant information).</p> <p>What quantifies basic terms has been defined by Anselm Eldergill Judge, Prof of Mental Health Law, at Court of Protection, Royal Courts of Justice, London, 2014.</p> <p>BPS (2019) <i>What makes a good assessment of capacity?</i> (Section 4.9)</p>
<p>D3. b) Whether the person could retain the information?</p>	<p>b) Is able/unable to retain the information long enough to make a decision at the material time that the decision is required to be made.</p>	<p>MCA Part 1, Section 3(1) (b) (p.2).</p> <p>MCACoP Chapter 4 (p.40).</p>

QUESTION	TASKS/ADVISORY NOTES	REFERENCE/ FURTHER GUIDANCE
D4. c) Whether the person could weigh information in regard to foreseeable consequences?	c) Is able/unable to use <i>and</i> weigh information in the balance, as part of the process of making the decision. Provide evidence of the person's rationale for any reasoning that s/he draws on to weigh information in the balance (e.g. a person making a decision to give a financial gift to someone may weigh up what the recipient has done for the person in the past against the impact of the loss of the money on the person's quality of life. Provide evidence that the person can apply this reasoning to their own personal situation (i.e. not just abstractly weigh up the risks and benefits, but rather be able to see how these could relate to their circumstances or needs).	MCA Part 1, Section 3(1) (c) (p.2). MCACoP Chapter 4 (p.40).
D5. d) Whether the person could communicate their decision?	d) Is able/unable to communicate his/her decision (whether by talking, using sign language or any other means). If another means has been used, provide a clear description of this and how it has been validated (e.g. if gesture, two people may have witnessed it and interpreted it to mean the same thing independently of each other).	MCA Part 1, Section 3(1) (d) (p.2). MCACoP Chapter 4 (p.40).
D6. If methods were used to enhance capacity, have they been clearly described?	If methods were used to enhance capacity you must make clear in the report that the person may only therefore have capacity in this exact set of circumstances, and that such enhances must be provided to enable the person to have capacity every time the specific decision in question is required to be made.	
D7. Has factual evidence been clearly distinguished from opinion?		Relevant professional guidelines (see reference list).

QUESTION	TASKS/ADVISORY NOTES	REFERENCE/ FURTHER GUIDANCE
<p>D8. Have you acknowledged as part of your opinion issues of reliability and validity that might have affected the assessment?</p>		<p>Relevant professional guidelines (see reference list).</p>
<p>D9. Have you duly considered and balanced different factors, ethical principles (i.e. autonomy versus protection) and value judgements (i.e. the person's values and wishes?).</p>	<p>Your clinical judgement needs to be clearly articulated showing your formulation and how you have weighed up a range of factors against each other and against the legal standards (e.g. as set out in diagrammatic representation by the American Bar Association (ABA) & American Psychological Association (APA) Capacity Handbook for Psychologists, 2008).</p>	<p>Relevant professional guidelines and Codes of Ethics (e.g. ABA & APA, 2008).</p>
<p>D10. Has your decision-making process been well structured?</p>	<p>Set out your decision-making process logically, working through the steps of the assessment.</p>	<p>Relevant professional guidelines.</p>
<p>D11. Has your opinion/judgement, based on the assessment, been clearly expressed?</p>	<p>If you are not the decision holder, ensure your report is addressed to them as advice, rather than a fait accompli (e.g. in my opinion X lacks the mental capacity to or has the mental capacity to...).</p> <p>If you are concluding that a person lacks capacity for a specific decision, ensure you have clearly indicated which parts of the functional test have not been met (i.e. understanding, retaining, using/weighing information or communicating a decision) and how these are directly caused by the impairment of mind or brain leading to this test being applied (i.e. document the causal relationship between these two aspects).</p>	<p>Relevant professional guidelines.</p> <p>BPS (2019) <i>What makes a good assessment of capacity?</i> (Section 2.9).</p>

E. Recommendations

QUESTION	TASKS/ADVISORY NOTES	REFERENCE/ FURTHER GUIDANCE
<p>E1. If the person is judged to lack capacity, are there recommendations for actions to empower and/or protect the person?</p>	<p>For example:</p> <ul style="list-style-type: none"> • It should be advised that a best interest meeting (BIM) is scheduled, assuming it is not an excluded area of decision-making (e.g. sexual relations, parenting, fertility, adoption, marriage, or where an advanced directive or appointee is in place in relation to the specific area of decision-making). • If recommending a BIM, comment on which stakeholders should be invited to attend the meeting. • If no family/next of kin advocate is available/capable of advocating impartially for the person recommend referral to independent Mental Capacity Advocate (IMCA). • If you are of the opinion that restrictions to the person's liberty should be imposed in order to protect the person from harm recommend what these restrictions should be and advise that they should be considered as part of the BIM. • If a deprivation of liberty is implemented as part of the care plan agreed via the BIM, advise that it would require registration as a Deprivation of Liberty Safeguard (DoLS) with the examinee's local authority. This is the process at the time of writing, but is likely to be replaced by Liberty Protection Safeguards in the future, subject to final Parliamentary approval and Royal Assent. 	<p>MCA 2005; MCA CoP, 2007.</p> <p>MCACoP, 2007.</p> <p>MCA, 2005; MCACop, 2007.</p> <p>Human Rights Act, 1998.</p> <p>Deprivation of Liberty Safeguards, 2007 (note that DoLS currently only apply in England and Wales to people receiving care from organisations subject to evaluation by the Care Quality Commission (CQC).</p>
<p>E2. If the person is judged to have capacity but at risk of making an unwise decision, are there recommendations for actions to protect the person?</p>	<p>Recommend:</p> <ol style="list-style-type: none"> a) A risk assessment is completed to identify risk of harm to self and/or others from unwise decision-making. b) Safeguarding meeting is held to evaluate the risk assessment and develop a management plan to minimise risk of harm to self and/or others from unwise decision making. Advise which stakeholders should attend this meeting (e.g. family/friends, police, social services, care agencies, any other multi-agency personnel with an interest/involvement in the examinee's welfare, or who might be affected by the unwise decision-making). 	<p>Care Act, 2014.</p>

QUESTION	TASKS/ADVISORY NOTES	REFERENCE/ FURTHER GUIDANCE
<p>E2. If the person is judged to have capacity but at risk of making an unwise decision, are there recommendations for actions to protect the person?</p> <p>Continued)</p>	<p>c) Referral for an independent advocate (if the examinee is a vulnerable adult and has no one else to advocate for them independent of health and/or social services personnel).</p>	<p>Care Act, 2014.</p>
<p>E3. Is there a recommendation as to whether the assessment should be repeated?</p>	<p>Specify the time frame within reassessment is advised.</p>	<p>Refer to relevant professional practice guidelines (e.g. regarding repeat neuropsychological assessments see Heilbronner et al., 2010).</p>

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Appendix B – Increasing capacity

Once a client's capacity has been identified as lacking, the cause of this needs to be understood so as to ascertain whether, with adjustments and input, a client could reach the requisite threshold for having capacity.

This is an important principle within the MCA and due attention must be given to this before determining that an individual lacks capacity. A number of practical strategies and approaches are set out for guidance.

MOOD

Where an individual cannot demonstrate the requisite knowledge due to depression or anxiety (as examples of the most commonly experienced mood disorders), a psychologist should consider the following:

- Change the time or venue of the appointments if this would put the client more at ease and/or improve their cognitive functioning e.g. where there is daily variation in mood.

- Consider a brief period of psychological intervention to assist with the mood disorder if it is mild.
- Consider medication for severe conditions and where decisions may need to be taken imminently, although this requires further assessment by a medical practitioner.

LEARNING OR INTELLECTUAL DISABILITY/ COGNITIVE IMPAIRMENT

There are a range of techniques suitable, dependent upon the client's level of ability including:

- Use simple, everyday words to explain the necessary information and ensure the client understands, paraphrasing where necessary.
- Offer information in shorter, more digestible and easier to follow chunks.
- Offer multiple sessions to determine the client's ability to learn and remember what they have been told.

- Provide short written information if the client is literate.
- Use symbols or pictures to represent the key areas where literacy is an issue.
- Consider a supportive third party who can reinforce necessary learning where appropriate.
- Consider advice or input from a speech and language therapist.

LACK OF KNOWLEDGE OF THE NECESSARY PROCEDURE

This may be apparent in a range of scenarios. For example, when considering a person's capacity to litigate, it will be important to ensure they have been provided with the necessary information in the first place including the various roles of professionals, the nature of the concerns expressed, possible options and outcomes and the various stages of the legal process. For example, have

concepts such as Child Arrangements Orders or Interim Care Orders been explained to them in appropriate language? It is only after this information has been appropriately described or explained to them and then, if the individual still cannot either understand the concerns or recall the necessary information, that they are deemed to lack capacity.

COGNITIVE DECLINE DUE TO A NEURO-GENERATIVE DISEASE SUCH AS DEMENTIA

Where there is clear evidence of cognitive decline, whether or not sufficient to reach diagnostic threshold for dementia, for example, a number of strategies for improving memory and therefore recall of the necessary information must be considered first including providing written aide memoirs, verbal prompts

or pictorial reminders. In some cases, where medication is considered appropriate, this may also be tried as a means of improving the person's overall cognitive functioning as well as issues impacting on their capacity.

Appendix C – Case examples

A number of case examples are presented to illustrate the structure and process of conducting mental capacity assessments across a range of capacity issues and in a number of fields. It is illustrative only; each case must be determined on its individual facts although general guidelines can assist a psychologist to consider the issues in their own case.

Case example: Severe brain injury and capacity to consent to a package of care

Current concerns

Communication impairments affecting the assessment of understanding and evaluation.

Relevant background information

38-year-old male (AA) with recent history of severe brain injury secondary to a left hemispheric stroke which affected his ability to understand language and to express his wishes verbally.

He also has physical limitations affecting mobility and self-care (right sided weakness and non-functioning right arm)

Capacity Question: Does AA have the mental capacity to consent to a discharge package of care in the community?

Preparatory Work:

Clarify what the options are in terms of community support so that these options can be presented clearly to AA. Liaise with speech and language therapist about ways to enhance communication. Speak with the treating team about potential areas of risk and how these might be managed so that this information can form part of the discussion about the discharge package.

Stage 1 Does AA have a disorder of mind or brain?

Yes – evidence from brain scans show extent of the damage caused by the stroke 4 months previously and this is also supported by his difficulties in function with movement and language.

Stage 2 the four functional tests

Does AA understand the information relevant to the decision

AA needs to know what support he will have to manage the limitations he now has and what the risks are for him around returning to the community with or without adequate support.

Communicating this information to AA in an appropriate format is crucial and ensuring that he has understood the information is not straightforward.

Stage 2 the four functional tests (continued)

Speech and Language Therapy assessment has highlighted that AA does not consistently use verbal or gestures (thumbs up/down) yes/no responses accurately. He is not able to provide verbal responses beyond a single word level. He will sometimes acknowledge with facial expression that he is confused or uncertain when asked again if that is what he meant. Repeated questioning however can frustrate him and result in his terminating the discussion. Simple diagrams and images help structure the presentation of relevant information where this can be presented in concrete images or single words e.g. home, hospital. More abstract concepts are difficult to present, e.g. possible risks, see below.

Does AA retain the information long enough to make a decision

Although AA is not able to verbally demonstrate that he remembers information from previous discussions he is able to demonstrate by pointing at words/images and by facial expression that he recalls his previous accommodation and that he had some support from Social Care prior to his stroke. In trying to understand what AA's learning and memory skills were, it was noted that he had demonstrated some ability to learn practical information since his stroke e.g. his way around the building, recognition of staff faces and roles etc. so there is corroboratory evidence that he can recall information that is clearly relevant to him.

Further assessment of memory and learning through standardised assessments is not helpful here due to the severity of his communication difficulties.

Does AA demonstrate that he can evaluate the information relevant to the decision

AA clearly states he wants to return to his home.

AA shrugs or waves his hand dismissively when asked about any risks. On different occasions single word and picture prompt cards about things that would be good about being home and things that could be more problematic were used to try to help the discussion e.g. asking him to pick out any card/image that might be difficult for him to manage at present or things that he feels he can manage without any help.

In order to make the information more relevant to him, home visits to his previous accommodation were set up to help him see the reality of his situation. During the visits AA did not demonstrate an understanding of his current difficulties on his ability to care for himself at home even when practical examples were used to explore his understanding e.g. access to the bed and options for moving the bed to make it more accessible. AA did express pleasure in being in his home and with his possessions. He did not show any evidence of safety awareness within his own accommodation e.g. reaching up for items that were out of reach without putting brakes on his wheelchair to enable him to stand safely.

Communication

AA's ability to express his wishes was restricted by his communication difficulties.

With familiar topics and in context he could demonstrate pleasure and dislike and other personal preferences. He could make choices in the moment between items or activities.

Where choices were more abstract or required him to incorporate information about his limitations post-stroke he could not demonstrate that he had understood the information and used it to weigh up his choice.

Opinion

AA has an impairment of mind or brain affecting his ability to make the decision in question. It is the opinion of the assessors based on repeated conversations with AA using words, pictures, prompt cards and gestures and having observed and worked with him on a daily basis over a four month period, that AA does not have mental capacity to make the decision about discharge to the community. AA's communication difficulties are such that he is not able to demonstrate that he has understood and weighed up the information relevant to the decision. He is consistent in what he is saying are his wishes.

Recommendation

AA is unable to demonstrate the mental capacity to make the decision to return to his own flat with a care package. It is his clear wish to return to his flat and efforts to provide a safe environment for him to do so should be considered in his best interests.

Reflections

The level and extent of communication impairment affected the assessment of understanding and reflection of the relevant issues. It was difficult to ascertain whether the information AA was using was based solely on his previous knowledge and understanding of his accommodation and his wishes. Evidence from real life examples around his inability to compensate safely for his stroke related difficulties or to take this into account were considered relevant factors. On balance the view of the assessors was that it was not possible to conclude that he could **communicate** that he was using and weighing the relevant information and this was the basis for stating that he lacked the capacity to make this decision.

Case example: Learning disability and capacity to make a medical decision

Current concerns

There is an established history of both learning disability and previous poor engagement with obstetric services.

Relevant background information

BB is a 40-year-old woman with a history of difficult pregnancies, some with medical complications, and poor engagement with services. She has a well-established history of a mild learning disability. She is currently pregnant with her eighth child and Children's Services are concerned she will drop out of services as the birth date gets close. BB's obstetrician assessed her as having capacity to determine whether she would have a natural or induced birth, which the L.A. are challenging.

Capacity Question: Does BB have the mental capacity to consent to choose when to have her baby – whether naturally when labour commences or medically induced?

Preparatory work prior to seeing BB:

Read all the documents available and ascertain what information is required for BB to be considered able to make her own decision within the ambit of the MCA. This included a meeting with the treating obstetrician and his team to advise on how BB's pregnancy was progressing and what the relative risks were.

Stage 1 Does BB have a disorder of mind or brain?

Yes – BB has a well-documented history of mild learning disability which has been previously assessed and which is available to the assessor.

Stage 2 the four functional tests

Does BB understand the information relevant to the decision?

The information required here was the relative risks to having a medically induced versus natural birth and information on how her pregnancy is progressing alongside the benefits and possible consequences of engaging, or not, with obstetric services. BB was able to recall all aspects of her pregnancy as well as previous appointments and, generally, what they had been for. She confirmed a mild iron deficiency and had agreed to an infusion. She was aware that, so far, her pregnancy was otherwise progressing well and that this contrasted with previous pregnancies where problems had developed. She expressed some concern about the medical staff, mainly what they would share with Children's Services but understood that they were there for both her and her baby's wellbeing whilst having a duty to inform the L.A. when her baby was due.

Stage 2 the four functional tests (continued)

BB recalled a previous home birth, which had almost resulted in her and the baby's death due to her haemorrhaging and lack of medical attention. She was aware that a home birth carried more risks and that there was no medical or clinical need for an induced birth and wished to proceed with the pregnancy until her baby was born naturally.

Does BB retain the information long enough to make a decision?

There were no problems identified with BB's ability to retain information. She showed ability to recall relevant professionals' names and appointments with them, as well as previous difficulties with earlier pregnancies and had good recall for more recent events.

Does BB demonstrate that she can evaluate the information relevant to the decision?

BB was able to show sufficient awareness of her own (and her partner's) position, those of her obstetric team and the L.A.'s. She expressed anxiety at the outcome following the birth and that this had led her to consider dropping out from services in order to avoid having her child removed. She was aware her obstetric team wished her to continue attending all appointments and to have her child in hospital due to previous concerns, but retained some mild anxiety and paranoia over their other roles too.

Communication

BB had no problems verbally communicating her position.

Opinion

BB has a mild learning disability. However, she does have capacity within the meaning of the Act in relation to the decision as to when and how her baby should be delivered.

Recommendation

BB has capacity to make this decision which remains between herself and her treating team.

Reflections

There was little hard evidence that BB did not have the necessary information to be capacitous in this area. However, given her previous near-death experience and that of her child's, her difficult engagement with services and considerable concern over the wellbeing of the child in her care once born, this was a situation in which BB's capacity required formal assessment within a legal framework.

Case example: Capacity to litigate

Legal issues

Significant child protection issues in relation to CC's grandchildren. She had been joined to family court proceedings where issues regarding her capacity to litigate had been raised.

Relevant background information

CC is a 62-year-old Eastern European woman who emigrated to the UK three years prior to this assessment. She had no known relevant history in terms of either learning disability or major mental health problems. She spoke adequate English as her second language. Her social situation was precarious with regards to both accommodation and limited finances.

Capacity Question: Does CC have capacity to litigate i.e. understand proceedings before the Court and instruct a solicitor?

Preparatory work:

Read all the documents available and recap the information needed in order to be able to litigate.

Stage 1 Does CC have a disorder of mind or brain?

No, on the available information, there is nothing on which to base a diagnosis. However, there are also significant gaps in the evidence due to CC only being resident in the UK for three years, therefore there is no information on her schooling or work history or, indeed, medical history. Therefore, to assist the Court, the functional arms of the test were still considered.

Stage 2 the four functional tests

Does CC understand the information relevant to the decision?

The information required here was the information being considered before the Court, professionals' roles and the basis on which decisions would be made and some awareness of the overall process. CC did not know anything about the Court, only what had triggered it i.e. significant child protection concerns and her grandchildren's removal into care. CC had attended court but had not been able to follow what had been said. She did not know the detail of why her grandchildren had been removed or, in considering the social worker's role, what this was; neither did CC know other professionals' roles including that of her own legal advocate or the Children's Guardian. She had been through some form of Court process in her home country, in what sounded like similar situations i.e. child protection-related but had no knowledge of the English court system.

Stage 2 the four functional tests (continued)

Does CC retain the information long enough to make a decision?

Yes, there was evidence that CC could recall information from proceedings to date in terms of attending Court, people's names and a broad outline of the concerns expressed.

Does CC demonstrate that she can evaluate the information relevant to the decision?

This wasn't clear on the information available. However, there was nothing to indicate a clear deficit and, therefore, on the balance of probabilities and given her other level of functioning, it was concluded that she would have the sufficient ability to weigh and consider information.

Communication

CC had no problems verbally communicating her position. Whilst English was a second language, she had a sufficient grasp of this.

Opinion

There is no evidence of impairment in the mind or brain although the evidence also has significant gaps. Whilst CC currently does not show any understanding of the core issues required to litigate, this is based on extensive lack of knowledge rather than inability and it is presumed that she will be able to litigate if given the right input and assistance.

Recommendation

CC requires a period of time and specific sessions to explain the Court process generally and in relation to this specific case. This should be completed over a number of sessions, supported by written notes. She should also have access to the Court documentation to assist her to think more about the case.

Reflections

In this case, CC's general anxiety, confusion over her general social and family situation, lack of court paperwork and lack of knowledge or any prior experience of not only family court proceedings but many English systems, had caused her to appear to professionals who did not know her well as if she may have a learning problem sufficient to require an assessment of her capacity to litigate.

Case example: Capacity to use social media

Current concerns

There is an established history of a moderate learning disability and previous risky online behaviour but DD wishes to go online and use Facebook in particular but also other social media platforms and online dating sites.

Relevant background information

DD is a 45-year-old woman with a moderate learning disability residing in supported accommodation. She has mild plasticity in her left arm and leg.

Capacity Question

Does DD have the mental capacity to choose to go online and, in particular, to use Facebook, Skype, Facetime and online dating platforms?

Preparatory work:

Read all the documents available including numerous previous capacity assessments across a wide range of issues. Spoke to staff who knew DD at the accommodation and read a report from her treating psychologist re how best to interact with DD. I also sought guidance on what the necessary issues were for capacity to access online social media platforms as well as familiarising myself with online social media platforms. I also did basic research on general online behaviour, which often places people at risk, and that DD should be able to make these same mistakes. DD had already completed two previous assessments in relation to social media which had concluded differently as well as subsequently completing a course of work around this involving both practical work and discussions. I also produced a visual sheet to picture the various potential online risks re identity theft, financial scams etc. I clarified the nature of the instructions as some were too vague to meaningfully assess within the meaning of the Act, finally agreeing on Facebook, Skype and online dating sites.

Stage 1 Does DD have a disorder of mind or brain?

Yes – DD has a well-documented history of moderate learning disability which has been previously assessed and which was available to the assessor.

Stage 2 the four functional tests

Does DD understand the information relevant to the decision?

The information required was that some people use social media to present as nice but in fact wish to harm others; the various ways in which they may do so online and what risks there are; that steps can be taken to prevent this, and a sufficient awareness of what these are. In summary, DD showed a basic awareness of some of the functions and uses of Facebook such as setting up accounts and accepting or refusing friend requests to stay in touch. She knew bad things can happen but not the nature or variety other than possible hurtful comments. She had not retained any information on privacy settings and did not know how to keep herself safe.

Stage 2 the four functional tests (continued)

She did not understand the lack of verification of people or the use of algorithms whereby people she does not know may be suggested to her. Also, such knowledge must be continually applied and DD does not show the ability to generalise her learning.

Does DD retain the information long enough to make a decision?

DD had not retained much of the information from the individual work completed. There was evidence of significant gaps in her retention in relation to key necessary information.

Does DD demonstrate that she can evaluate the information relevant to the decision?

No, as DD cannot understand many of the core concepts and information points, she cannot use these to weigh up various options and to make a choice.

Communication

DD had no problems verbally communicating her position.

Opinion

DD has a moderate learning disability. She does not have capacity within the meaning of the Act to choose whether or not to use social media platforms including Facebook.

Recommendation

DD's mood and overall wellbeing are affected by her ability to communicate with family and friends, including online and, until this had been removed DD had used this in relation to family. As she lacks capacity but definitely wants to be able to access Facebook and gets upset, a best interests decision should be made as soon as possible, weighing the potential risks against the benefits of DD still using online social media platforms but doing so with the support of staff.

Reflections

This was a difficult case. DD had placed herself at potential risk through online behaviour and giving out personal information and, therefore, there had been a real risk of harm. She did not and was unlikely to be able to reach the necessary, even low, threshold of awareness to be considered capacitous in this area and, yet, not accessing Facebook in particular was also having a detrimental impact on her overall social and emotional wellbeing. The conclusion was that, whilst she does not have capacity, consideration should be given to making a best interests decision to support her online activity.



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