Assessing mental capacity

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Abstract
This article is based on a presentation that I gave to the Royal Hospital for Neuro-disability, Putney, London on 28 July 2010. It draws on case law and case studies to explore the issues and dilemmas involved in assessing a person's capacity to make decisions. Suggestions are proposed for the stages in undertaking that assessment. The article concludes by emphasising the importance of considering best interests as a factor in deciding whether a person has capacity in relation to a particular decision, where there may be concerns as to his/her vulnerability overall.

Key words
Mental Capacity; best interests; vulnerability.

Introduction
I am a professional Deputy for property and financial affairs under the Court of Protection. I have a niche interest in brain injury work including personal injury trusts, and have specialised in this field for a number of years. I advise regarding powers of attorney, financial abuse cases, and all contentious aspects of Court of Protection work, including care and welfare matters. In conducting this work, I have become aware that practitioners often struggle with assessing mental capacity. This article draws on anonymised case studies to explore the difficulties that can arise and case law to highlight current best practice. It then provides steps on how to conduct an assessment of capacity, emphasising the usefulness of a best interests assessment as a tool in this process, particularly where there are concerns as to the vulnerability of the individual being assessed.

Background
The *Mental Capacity Act* (MCA) *2005* (HM Government, 2005) has given legal and medical practitioners an enhanced legal test based on common law, which is to be applied in assessing mental capacity. It is a test that has been challenging for psychologists, psychiatrists, and other medical practitioners alike. The Court of Protection Form 3 (COP3) now needs to be completed to assess capacity. In completing the COP3 form, it is preferable that the instructions provided to the medical practitioner are as clear and specific as possible. This is particularly important in terms of what is being sought to be achieved for the vulnerable person (referred to as 'P' under the *Mental Capacity Act 2005* and referred to from now on as the 'patient'). That is to say, every patient's needs are different, as is every patient's situation. It is helpful to the practitioner concerned, therefore, if they are at least aware of the profile of the patient concerned or what is being decided or will be required to be decided on his/her behalf in order to take the matter forward. This in turn will indicate to the practitioner whether or not it will be appropriate to set up ongoing reviews of capacity and, if so, how often.

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Most of my clients have acquired brain injuries through disease, medical negligence, or road traffic accidents. I have found that not only is every case vastly different, particularly in terms of the more complex cases, but also an assessment of a patient's mental capacity to manage his/her property and financial affairs will usually turn on the particular facts and circumstances of a given case. For example, 'Nick' is in his 40s. There is absolutely no argument at all that, due to the nature of his injuries sustained in a road traffic accident, both to his brain and his body, he lacks capacity to manage his property and financial affairs. He is in fact unable to communicate. However, 'Hank' has borderline capacity following a brain injury and he can now make more decisions than he could two years ago. Assessment of my clients' levels of capacity in respect of different types of decision consequently requires consideration of a multitude of different factors.

The guiding principles of the *Mental Capacity Act 2005*

All actions taken on behalf of a patient where he or she lacks capacity under the *Mental Capacity Act (MCA) 2005* (HM Government, 2005), need to have followed the principles set out as follows.

1. Assumption of capacity – '*A person is assumed to have capacity unless it is established that they lack capacity*' (MCA, section 1(2)).
2. Enable people to make decisions – '*A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success*' (MCA, section 1(3)).
3. Capacity does not necessarily mean wisdom – '*A person is not to be treated as unable to make a decision merely because he makes an unwise decision*' (MCA, section 1(4)).
4. Always act in a person's best interest – '*An act done, or a decision made, under this Act, for or on behalf of a person who lacks capacity must be done, or made, in his best interests*' (MCA, section 1(5)).
5. Adopt the least restrictive intervention – '*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*' (MCA, section 1(6)). One is mindful here of the *Human Rights Act 1998* (HM Government, 1998).

Each of these principles plays a central role in the following assessment process.

Assessing capacity

Step one: establishing the context to the assessment

It is essential to gather the following information to help to inform the assessment.

- Who is the patient?
- What is their mental/psychological condition?
- Do we know what is sought to be achieved for him/her?
- What are the other relevant surrounding circumstances?
- Are there any people whose interests or wishes need to be considered?
- Are there any previous relationships to consider?
- Are there any abusive elements?

Establishing the context enables the assessor to be able to consider the best way to conduct the assessment. Is there a certain time of day (particularly in cases of dementia), to find the person at their best? It is important to take the time to decide how to conduct the interviews with the patient and to plan the questions so as not to lead them to 'yes' or 'no' answers. This also necessitates establishing the best way to communicate with the person and ensuring that they are in an environment in which they feel safe, comfortable and not distracted. Taking time over the assessment is important – do not do it in one day – spread it out over a period of time. Setting up an ongoing review system is also helpful, particularly in borderline cases. Gone are the days when capacity assessments

could be completed and forgotten about since legal and medical practitioners are now under an active duty to reassess and review capacity on an ongoing basis.

Step two: the 'UWRC' test

The legal test for lack of capacity is based on the idea that a patient is unable to make various decisions for himself/herself in relation to a matter or matters concerning his/her property and affairs because of an impairment of, or by a disturbance in the functioning of, his/her mind or brain. It is also based on the need for the patient to be able to understand; weigh; retain and communicate decisions (which I refer to as 'the UWRC test').

The significance of 'best interests'

Overarching this test is the umbrella of 'best interests' enshrined in section 4 of the *Mental Capacity Act 2005*. It is the application of the best interests test that in borderline cases can often assist us to establish whether a given patient lacks mental capacity to manage their own property and financial affairs or not. This is often due to the fact that they may pass the 'UWRC' test but lack insight or show evidence of unequivocal vulnerability in the community. Applying the best interests test in an objective way also allows one to step away with confidence from the function and/or time-specific application of the legal capacity test. How this can work in practice can be shown by way of example, in that a patient may be able to make uninformed decisions or exercise bad judgement on their own behalf at a particular time and in relation to a particular set of facts. Applying the best interests test can enable the medical practitioner to look objectively at the patient's needs overall, and in relation to those particular facts and circumstances that are presented to him. The practitioner is therefore not being asked to give his own point of view in relation to a particular patient or indeed those particular facts and circumstances, but rather, to step back and give as objective a view as possible as to what decision should be made on behalf of the patient, as opposed to those decisions he should be allowed to make for himself. If a patient is vulnerable or at risk of financial or other forms of abuse, or if his level of insight into his own circumstances is such that, if he were left to his own devices, not only would he make unwise decisions but he would lose all his money, then an assessment of lack of capacity should be given.

One could argue that medical practitioners are being asked to take bold steps. Indeed, I am aware that in a number of cases, some practitioners are refusing to complete COP3 forms. Therefore, it will be helpful to practitioners to see further legal cases coming through, whether on a reported or unreported basis, to provide assistance to practitioners.

In that regard, the case of *Re P* [2009] WTLR651, [2009] LSLawMed264 [2009] EWHC163 (Ch) (Mr Justice Lewison, 9 February 2009) assists us. The case involves a statutory will application. Mr Justice Lewison considered the difference between substituted judgment and best interests and held that the earlier law regarding the making of statutory wills (the landmark decision of Sir Robert MeGarry V-C in *Re D (J)* [1982] 2 All ER 37), is no longer good law, because it applied the substituted judgment test. *Re P* shows us that it is still important to take into account the patient's previous views, ie. prior to their mental illness, disease or brain injury. Likewise, the patient's past beliefs and feelings for those around them are still relevant. However, views, beliefs and feelings are no longer deciding factors. It is true that *Re P* was decided on its particular facts, and it is clear from the judgement that one should no longer be trying to assess or imagine the patient's wishes in a snapshot in time. Rather, one should apply the objective best interests test, which requires one to know one's patient. Above all, applying the best interests tool enables us to reach a decision on their behalf that has involved an appropriate analysis of all the relevant facts and circumstances, and the weighing up of all the patient's views and beliefs. This brings

one to a conclusion in a given case that is, one would hope, as objectively appropriate for the patient as possible.

Case discussion

n Hank's case, mentioned earlier, he is well ble to pass the URWC test. However he still far too vulnerable to be left to run mok with his money. He can manage a nall budget and contributes to financial iscussions. He also takes a keen interest his finances overall. However, his ulnerability prevents him from being able discharge himself from the Court of otection. Nevertheless, it is important to ork with him to enable him to make as any decisions as possible. Here the best terests' objective test overrides 'factual-ecific' consideration of his decision-making ility on a micro level.

In another case 'Joan', who is in the early ages of dementia, had signed a Lasting wer of Attorney and she is now in a uation where family members and friends spect her attorney of financial abuse. Her orney is related to her. Significant monies em to have disappeared. In establishing ether or not Joan had capacity to sign asting Power of Attorney in a situation fluctuating capacity, the case of *Re K, F* [1988] 1 All ER 358 comes to mind. wever, this case applied to capacity to ecute enduring powers of attorney, ie. one eds to understand the nature and effect of document.

It was not clear whether Joan lacked acity. Therefore, in this case it was nsidered appropriate for the local authority sess her and establish her best interests, ticularly given that she was very frail had specific care needs, as well as being ely and with a diagnosis of vascular mentia. Joan was very close to her attorney this did not mean that she had the acity to execute the Lasting Power of rney or understood the implications of ng done so. Perhaps the case of *Re M, A v Z and others* [2009] WTLR1791, [2009] C 525 (Fam) (Mr Justice Munby, 12 ber 2009) would assist here. Mr Justice Munby considered a statutory will application where an elderly lady had been the victim of financial abuse by a neighbour. He held that the weight attached to her wishes would have to be case-specific and fact-specific. That is to say, in some situations those wishes may carry more weight than in others. The weight will depend on the individual circumstances of a particular case. He went on to say that any weight to be attached to the patient's wishes and feelings will be issue-specific, just as the capacity test under the MCA is also issue-specific. There is no one factor in section 4 that has a higher value than any other. In a given case, however, there may be one factor that stands out above all others. I am inclined to think that had Joan not died before matters were resolved, the fact that the decisions she was making in relation to her care and her finances were making her frailer and were depleting her bank account, would override any issue-specific assessment of her views about the particular attorney concerned.

In a third example, 'Ryan' had a girlfriend, 'Sally', at the time of sustaining a traumatic brain injury in a car accident. It subsequently became necessary to take Sally to the Family Court to have her removed from his property. The Judge accepted the abuse she was perpetrating on him. A best interests assessment was carried out by the local authority to assist in collation of the evidence required for the Non-Molestation Order and Non-Occupation Order applications, which were then granted by the Family Court Judge. Ryan was so lacking in insight into situations where he was being abused that he was clearly vulnerable to an unacceptable level.

Conclusion

The law relating to mental capacity for property and affairs and for personal welfare is a burgeoning area. It will be interesting to see how the law develops in these areas. In the meantime it is hoped that medical practitioners being instructed to complete COP3 forms will be more confident in applying the legal test, and objectively assessing patients' best interests. Practitioners should expect to disagree in arriving at

one to a conclusion in a given case that is, one would hope, as objectively appropriate for the patient as possible.

Case discussion

In Hank's case, mentioned earlier, he is well able to pass the URWC test. However he is still far too vulnerable to be left to run amok with his money. He can manage a small budget and contributes to financial discussions. He also takes a keen interest in his finances overall. However, his vulnerability prevents him from being able to discharge himself from the Court of Protection. Nevertheless, it is important to work with him to enable him to make as many decisions as possible. Here the best interests' objective test overrides 'factual-specific' consideration of his decision-making ability on a micro level.

In another case 'Joan', who is in the early stages of dementia, had signed a Lasting Power of Attorney and she is now in a situation where family members and friends suspect her attorney of financial abuse. Her attorney is related to her. Significant monies seem to have disappeared. In establishing whether or not Joan had capacity to sign a Lasting Power of Attorney in a situation of fluctuating capacity, the case of *Re K, Re F* [1988] 1 All ER 358 comes to mind. However, this case applied to capacity to execute enduring powers of attorney, ie. one needs to understand the nature and effect of the document.

It was not clear whether Joan lacked capacity. Therefore, in this case it was considered appropriate for the local authority to assess her and establish her best interests, particularly given that she was very frail and had specific care needs, as well as being elderly and with a diagnosis of vascular dementia. Joan was very close to her attorney but this did not mean that she had the capacity to execute the Lasting Power of Attorney or understood the implications of having done so. Perhaps the case of *Re M, ITW v Z and others* [2009] WTLR1791, [2009] EWHC 525 (Fam) (Mr Justice Munby, 12 October 2009) would assist here. Mr Justice Munby considered a statutory will application where an elderly lady had been the victim of financial abuse by a neighbour. He held that the weight attached to her wishes would have to be case-specific and fact-specific. That is to say, in some situations those wishes may carry more weight than in others. The weight will depend on the individual circumstances of a particular case. He went on to say that any weight to be attached to the patient's wishes and feelings will be issue-specific, just as the capacity test under the MCA is also issue-specific. There is no one factor in section 4 that has a higher value than any other. In a given case, however, there may be one factor that stands out above all others. I am inclined to think that had Joan not died before matters were resolved, the fact that the decisions she was making in relation to her care and her finances were making her frailer and were depleting her bank account, would override any issue-specific assessment of her views about the particular attorney concerned.

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their decisions, particularly in borderline capacity cases. However, it will often be clearer cut, particularly where there are issues of vulnerability and/or lack of insight on the part of the patient if the best interests assessment is applied.

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