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Assessment of mental capacity: a flow chart guide

The Mental Capacity Act 2005 provides a new legal framework within which health and social care professionals (as well as informal carers) must act when providing care and treatment for the estimated 2 million people in England, Wales and Northern Ireland who lack the capacity to make certain decisions for themselves. Although the Mental Capacity Act 2005 Code of Practice provides comprehensive advice on good practice in assessing capacity, it does not identify a specific process to be used. Good clinical practice depends on the exercise of clinical judgement within a valid and contestable process. This article outlines a flow chart (Fig. 1) that can be used to guide the process of capacity assessments in more complex cases, in line with the Mental Capacity Act 2005 and the Code of Practice.

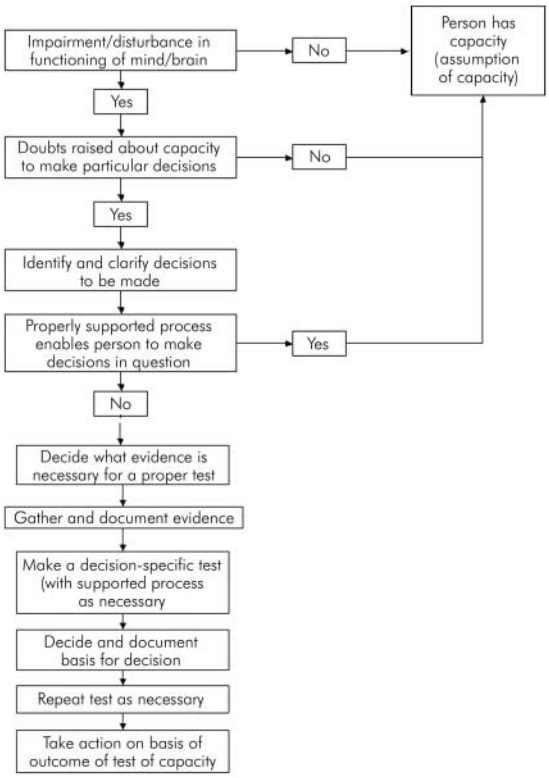

Fig. 1. Flow chart guide to the assessment of capacity.

Impairment/disturbance in functioning of mind/brain

The 'assumption of capacity' is the overriding principle of capacity assessment. This states that a person is deemed to have capacity unless it is proved that they have an impairment or disturbance of mental functioning (such as an intellectual disability, dementia or other cognitive impairment, acquired brain injury or mental illness) and this impairment is sufficient to affect their capacity to make a particular decision. Clinicians should assess and diagnose such impairment before assessing capacity. The Act preserves the right of individuals without such impairment (and those with impairment who have capacity for the decision in question) to make unwise or risky decisions, and it is emphasised that lack of capacity cannot be attributed simply because of appearance, condition, age, religious or cultural beliefs, and eccentric or idiosyncratic behaviour.

Doubts raised about the capacity to make particular decisions

Once an impairment or disturbance of mental functioning is detected, a clinician should be aware of the likely impact on capacity. Thus, certain factors are more predictive of lack of capacity than others, for example the presence and severity of cognitive impairment (including lower scores on the Mini-Mental State Examination; MMSE; Folstein *et al*, 1975), diagnoses such as psychosis and bipolar disorder, and presence of delusions; other factors, such as degree of psychopathology and age show a less consistent relationship (Cairns *et al*, 2005; Jeste & Saks, 2006). There is considerable heterogeneity within diagnostic groups, and factors (such as cognitive impairment) that have the most significant association with impaired capacity explain no more than 25% of the variance (Jeste & Saks, 2006). With this in mind, clinicians should consider routinely using simple open-ended screening questions to detect reduced capacity, for example 'why might it be difficult for you to manage safely at home?' for placement decisions, and 'what is this treatment about?' for treatment decisions. Palmer *et al*

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(2005) have shown such an approach to be effective for screening for capacity to consent to research.

Identify and clarify decisions to be made

Capacity is decision-specific, therefore lack of capacity can relate to any area of decision-making and may affect some decisions but not others in a particular decision area (reflecting changes in complexity of the decisions). For example, a person may retain capacity to manage their medication on a daily basis but may not have the capacity to decide whether to undergo a surgical procedure. It follows that careful specification of the decision in question is the basis on which a properly supported process can be used and a valid capacity assessment made.

Properly supported process enables person to make the decision in question

Within the Mental Capacity Act 2005, if a 'properly supported process' is sufficient to enable the person to make the particular decision, they are assumed to retain capacity (although vulnerable). Therefore, clinicians are required to take 'all practicable steps' to support decision-making. The main areas mentioned in the Code of Practice include: providing all relevant information (including simplifying information, outlining benefits and risks, considering effects on others); enhancing communication; and making the person feel at ease (considering, for example, location, timing and support from others). Research has identified a number of ways for enhancing capacity including: education (Lapid *et al*, 2004); multiple learning trials with corrected feedback (Wirshing *et al*, 1998); and enhanced structure using computer-based presentations (Dunn *et al*, 2002). In line with this research, there is scope for ward-based procedures to be developed to both support and evaluate level of independence in specific decision-making areas when preparing for discharge, for example a graded self-medication procedure for in-patients receiving stroke rehabilitation. Finally, it is noted that careful attention should also be given to written materials such as consent forms, which can be improved by use of structure and uniformity, shorter sentences and words, and simplified or illustrated formats (Dunn & Jeste, 2001).

If a properly supported process does not enable the person to make the particular decision, a 'capacity assessment' is required. All those taking some action on behalf of those in their care will be expected to be able to assess capacity. This will often be a relatively informal, straightforward process (for example for relatives and carers), in which a 'reasonable belief' of lack of capacity when acting for someone is enough to provide statutory protection.

The more serious the decision, the more formal the assessment required, and an explicit or formal process, such as that suggested next, should be considered under certain circumstances, for example if the decision involves a significant life change (such as placement decisions), in legal decisions (wills and advanced decisions regarding withholding treatment etc.), and with complex cases (for example where professionals, the person or different family members disagree). Risk is another trigger, for example where a treatment or study has more than a minimal risk, if there is a risk of harm by making or not making particular decisions, and where there is risk of, or actual harm or exploitation by others. A formal process might also be considered in research protocols where a proportion of potential participants might be expected to lack capacity.

Decide what evidence is necessary for a proper test

The patient and their significant others will be able to provide critical information regarding the decision to be made. Specialist opinions may be required, such as from a psychiatrist, other medical specialists with relevant expertise, a clinical psychologist or neuropsychologist. Detailed neuropsychological assessment is of particular value in identifying those types of cognitive impairment, such as dysexecutive syndrome, that may not be detected with standard orientation or psychiatric screening tests (such as the MMSE), but often have a significant impact on capacity (Kim *et al*, 2002). Objective and relevant evidence about a person's functional abilities and behaviour from other health professionals is also important, for example occupational therapists, physiotherapists, nurses and dieticians, and can be used to identify a mismatch between what is said and actual behaviour, reflective of impaired capacity.

Gather and document evidence

Information gathered should be documented carefully and specifically, as it must withstand the scrutiny of independent audit. The validity and reliability of evidence will need to be considered, as it may be affected by a number of factors, for example the level of knowledge and understanding about the mental impairment, the nature of the decision to be made and any vested interests of those providing information.

Make a decision-specific test

A number of assessment instruments are available for assessing capacity in treatment and research settings (Dunn *et al*, 2006). Although useful, these are not a substitute for a clinical interview (and clinical judgement) which is necessary, not only to allow the requirements of a legal test of capacity to be met but also to test the potentially wide range of decisions necessary, provide properly tailored support and enable consideration of relevant evidence such as previous actions and observed behaviour (such as in activities of daily living). The clinical interview must test the person's ability to meet all four criteria of capacity defined in the Act. A person has capacity in relation to a specific decision if they:

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- understand the information relevant to the decision
- can retain the information, even if only for short periods
- can use or weigh the information relevant in the decision-making process, including seeing both sides of the argument and being able to make a decision one way or the other
- can communicate their decision by talking, using sign language or another form of communication understood by others.

It is important to provide full support (during, or in additional, clinical interviews) before it is decided the person lacks capacity, and to tailor this support to try to remedy any problems identified in these four criterion areas. These will be briefly considered next. Providing relevant information is central to supporting understanding, but even when this is given, a person may fail to understand if they do not believe this information (for example the person continues to believe they are eating or drinking sufficiently to remain healthy, when objective evidence demonstrates this is not so). If support in the form of corrective information fails, then under some circumstances a behavioural experiment may be instituted to enable erroneous beliefs to be tested and gently challenged. However, the supported process and assessment must always be consistent with the principles of the Mental Capacity Act 2005. For example, as a result of religious, cultural or idiosyncratic personal belief, a person may make an unwise/risky decision that is at odds with the clinician's view, and the right to do this is protected. Such situations must be handled sensitively, assessing and supporting the person's level of understanding of the risks arising from a particular decision based on a belief (such as refusal of certain medical interventions), and respecting this decision if some appreciation of the risks is shown. If no appreciation of the risks is shown for this decision then the person should be regarded as lacking capacity, but it is noted that any decisions or actions taken on their behalf will still need to take account of the individual's beliefs (under the best interests' principle).

If the person is unable to retain information, then memory aids such as diaries, video and voice recorders may be useful, and if the decision made is forgotten the person can still be found to have capacity if, when taken through the same process on subsequent occasions, they come to the same decision. Difficulty in using or weighing information may be reduced by simplifying choices, for example developing two alternative scenarios that omit detail but identify all the important benefits and risks. However, if the person cannot choose between these even with proper support, they will fail the test of capacity. Lack of capacity as a result of inability to communicate is relatively less common and joint assessment with speech therapists is recommended when the ability to meet this criterion is in doubt.

Decide and document basis for decision

In the Mental Capacity Act 2005 a decision about whether or not the person has capacity must be made on the balance of probabilities. Thus, for example, if the weight of the evidence is 49–51% that the person has capacity then it must be decided that they do, and vice versa. The decision made may have certain limits, for example for patients with illnesses with fluctuating course, such as vascular dementia, where on one occasion they may be able to make the decision and on another may require a supported process or lack capacity regarding that decision. Other situations may include time limitations in an illness that may improve, and how to support vulnerable adults through the process. Again, the documentation must stand up to independent scrutiny.

Repeat test as necessary

Given the limits of the decision taken, the capacity test will need to be repeated as required. This will be every time a doubt is raised about a person's capacity to make a particular decision, if their illness changes in any way, if a significant time period has lapsed since the previous assessment, or if the treatment or protocol has a long time period with a risk of delayed side-effects (such as with antipsychotic medication).

Take action on basis of outcome of test of capacity

Any decision made must be in the patient's best interests, ensuring the statutory checklist is always taken into account. The Mental Capacity Act 2005 Code of Practice checklist includes the following areas:

- equal consideration and non-discrimination
- considering all relevant circumstances
- regaining capacity
- permitting and encouraging participation
- special considerations for life-sustaining treatment
- the person's wishes and feelings, beliefs and values
- the views of other people.

The decision should involve the patient, their relatives and if required, a mental capacity advocate, and should be the least restrictive solution possible. The decision should be communicated to the relevant parties – the patient, their relatives and other professionals involved in their care, including health, social services and voluntary agencies – so that appropriate action can be taken. Circumstances under which seeking a second opinion should be considered are if the person, family or advocate, disagree with the assessment, and in cases where substantial consequences result from the outcome and there was only a small margin of error in the assessment (Buchanan, 2004).

Discussion

Clinicians assessing capacity must be able to demonstrate that they are familiar with, understand and have followed the Mental Capacity Act 2005 Code of Practice. Although certain issues, such as how to protect people who lack

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capacity, not under compulsion but deprived of their liberty, have yet to be finalised under the Mental Capacity Act 2005 and proposed Mental Health Act 1983 amendment, we trust that the flow chart will facilitate good practice, providing a guide to the process of assessing capacity in more complex cases.

Declaration of interest

None.

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Working with asylum seekers with mental illness distressed by the Home Office dispersal programme

Successive UK governments have introduced increasingly tough asylum policies. Recent immigration legislations (for example the Asylum and Immigration Act 1999 and the Nationality, Immigration and Asylum Act 2002) have continued this tradition. The dramatic reduction in asylum applications by 54% between 2002 and 2004 (Heath & Jeffries, 2005) suggests these measures are effective and hence politically attractive.

One of the major initiatives introduced by the Asylum and Immigration Act 1999 is the dispersal of newly arrived asylum seekers from London and the South-East to other parts of the UK. Although the dispersal programme has proved controversial, it is supported by economic and political arguments. For instance, long-term accommodation is more readily available and cheaper outside London and the South-East. Also, as the major entry ports to the UK are in the south-east of England, without dispersal the region is likely to continue hosting disproportionate numbers of asylum seekers. This could lead to excessive pressures on services and resentment by local communities.

Nevertheless, post-migration adversities (like dispersal) are associated with higher rates of psychiatric disorder in refugees (Sack *et al*, 1996, Heptinstall *et al*, 2004). For vulnerable asylum seekers, dispersal could mean loss of newly established support networks. Also press reports of serious racially motivated crimes against dispersed asylum seekers (Macleod, 2002) could be unsettling.

Although many asylum seekers may cope well with dispersal, some become distressed. This paper discusses some of the issues around working with asylum seekers referred to mental health services as a result of a dispersal-related mental disorder. Supporting this client group can be challenging as it involves working with agencies and procedures which most mental health clinicians are unlikely to be familiar with.

The paper is based on the author's experience of working with this client group, discussions with other professionals with expertise, and resources from statutory and voluntary organisations working with asylum seekers. References and links to these resources are provided (see also Box 1 for a list of relevant Acts). The paper examines some general issues about dispersal and considers two scenarios to illustrate the issues highlighted. The UK immigration and asylum processes