Hampshire Safeguarding Adult Board
Safeguarding Adult Review regarding 'Sasha'

Who was Sasha?

Sasha was 20 years old and had a long history of mental health illness and missing episodes since the age of 15. Before her death, she was under the care of several health services and as a child had been supported by the Child and Adolescent Mental Health Services (CAMHS). On the evening she died, Sasha was found in a serious condition by a lake in a country park close to where she lived. She died shortly afterwards in hospital from a suspected overdose of propranolol. The Coroner confirmed that Sasha died as a result of suicide following a deliberate fatal overdose of propranolol tablets.

Sasha had a longstanding difficulty with her mental health and well-being that led to several diagnoses from childhood into adulthood. She found transition from children's services into adult services particularly difficult appearing to trigger an escalation of stresses and self-harm behaviours.

Efforts to contain her stresses with various therapies and medications did not appear to alleviate her self-harm with overdoses and self-laceration. It cannot be underestimated how Sasha's extensive and very controlling OCD rituals and behaviours impacted on all efforts by professionals and her parents to find treatments and therapies that would be successful.

This briefing covers the following learning points from the SAR:

SAR Learning Point 6: *The Provisions of the Mental Health Act should be applied robustly in order to ensure safety and treatment. This will prevent confusion as to the status of a detained person as well as clarity regarding use of the Mental Health Act and/or Mental Capacity Act.*

Learning Point 7: *Mental Capacity needs careful and robust assessment where a person is presenting with severe self-harm and suicide behaviour and is refusing treatment'.*

Learning Point 8: *Advance decisions should always attract questions and seeking of legal advice in cases of self-harm and suicidal behaviour.*

Briefing Introduction

The interface between physical health, mental health and mental capacity is complex and requires a degree of legal literacy and in many cases the need to seek legal advice.

The two Acts are inextricably linked, interacting in many areas, the Code of Practice for the MHA states that 'it will be difficult for professionals involved in providing care for people with mental health problems to carry out their work (including their responsibilities under the Act) without an understanding of the key concepts in the MCA'.

As a starting point it is important to understand the key differences in both pieces of legislation before the overlaps are explored. It is important to understand the legal rules of the MHA 1983 and the MCA 2005, so that all legal options are explored when a person is refusing treatment and is deemed to have a mental disorder.

The Mental Health Act 1983

Provides a legal framework for the treatment of patients with mental disorder, without which there would be a risk of harm to the patient's health or safety or a risk of harm to others. If the criteria are met the Mental Health Act can be applied to a person **with capacity** without that persons consent or may be applied to a non-compliant or dissenting patient who lacks capacity and for whom detention is necessary. The MHA provides ways of assessing, treating and caring for people who have a serious mental disorder that puts them or other people at risk. It sets out when:

- People with mental disorders can be detained in hospital for assessment or treatment
- People who are detained can be given treatment for their mental disorder without their consent (it also sets out the safeguards people must get in this situation)
- People with mental disorders can be made subject to guardianship or after-care under supervision to protect them or other people
- Under section 18(1) of the MHA 1983 patients absent without leave may, (subject to the provisions of this section) be taken into custody and returned to the hospital or place by any approved mental health professional, by any officer on the staff of the hospital, by any police constable, or by any person authorised in writing by the managers of the hospital.

Most of the MHA does not distinguish between people who have the capacity to make decisions and those who do not. Many people covered by the MHA have the capacity to make decisions for themselves and may still be subject to treatment for their mental disorder.

What about physical treatment when the person is liable to be detained under the MHA?

Subject to certain conditions, Part 4 of the MHA allows doctors to give patients who are liable to be detained, treatment for mental disorders without their consent, whether or not they have the capacity to give that consent.

This may include treatment of physical conditions that is intended to alleviate or prevent a worsening of symptoms or a manifestation of the mental disorder or where the treatment is otherwise part of, or ancillary to, treatment for mental disorder.

In other words, if a person is detained under the MHA, and needs physical health treatment that is related to their mental health problem, then this treatment can be given under the MHA. An example may be a person who has self-harmed and needs medical attention. This includes patients on longer term sections (sections 2, 3, 36, 37, 38, 45A, 47 and 48).

Patients detained under a section to which treatment powers apply, but granted leave of absences are still covered by the treatment powers of the Act, so the rules and procedures apply in the same way. Where Part 4 of the MHA applies, the MCA cannot be used to give medical treatment for a mental disorder to patients who lack capacity to consent. This is because Part 4 of the MHA already allows clinicians, if they comply with the relevant rules, to give patients medical treatment for mental disorder even though they lack the capacity to consent. In this context, medical treatment includes nursing and care, habilitation and rehabilitation under medical supervision.

Where individuals liable to be detained under the Act have a physical condition unrelated to their mental disorder, consent to treat this physical condition must be sought from the individual. If the individual does not have the capacity to consent, treatment can be provided under the MCA as long as it is in their best interests.

The Mental Capacity Act

To fall within the scope of the MCA, the person has to be 16 or over and assessed as lacking the relevant capacity within the meaning of the Act: 'For the purposes of this Act, a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.' (MCA section 2(1)).

The provisions of the MCA, such as best interests decision making (MCA section 4 and section 5), using restraint and restriction (MCA section 6) and depriving a person of their liberty (MCA sections 4A and 4B) and schedule A1 (DoLS) cannot be applied to people who have capacity to make the relevant decision.

The interface between the Mental Capacity Act (MCA) 2005 and the Mental Health Act 1983 (MHA)

The interface between physical health, mental health and mental capacity is complex. It requires a degree of legal literacy and in many cases the need to seek legal advice.

If somebody is 16 or over and lacks capacity for a specific decision and is experiencing a mental disorder, then potentially, they may come under both the MHA 1983 and the MCA 2005.

Examples might be in respect of the following:

- Issues of vulnerability/safeguarding concerns about a person's ability to make decisions around sexual relationships or finances
- Disengagement from services, does the person have capacity to disengage?
- Admission and detention in a mental health hospital.

What about treatment decisions?

When someone is **NOT** detained under the Mental Health Act, any care or treatment must be with the patient's consent or through the MCA (they lack capacity, and it is in their best interests).

For example:

- ***Hull University Teaching Hospital NHS Trust v KD [2020] EWCOP 35.*** A woman with paranoid schizophrenia in need of an operation for a collapsed lung, to which she objected. The court found she lacked the mental capacity to consent to surgery and it was in her best interests to have it.

What about treatment decisions when the person is liable to be detained?

- **People on Section 5(4), 5(2), 4, 136, 135** of the Mental Health Act 1983. These sections do not contain any power to treat so **any** treatment/care given must be with their consent or via the MCA.
- **People on Section 2 or 3 or 37** etc. of the Mental Health Act 1983. Part 4 of the MHA allows doctors to give patients, who are liable to be detained treatment for mental disorders without their consent, whether or not they have the capacity to give that consent. This may include treatment of physical conditions that is intended to alleviate or prevent a worsening of symptoms, or a manifestation of the mental disorder or where the treatment is otherwise part of, or ancillary to, treatment for mental disorder. **In other words, if a person is detained under the MHA, and needs physical health treatment that is related to their mental health problem, then this treatment can be given under the MHA. An example may be a person who has self-harmed and needs medical attention.**
- Physical care/treatment not related to the mental disorder require the person's consent or the MCA applies for these decisions.

How do I know if a person is consenting?

It is important to start with the assumption that a person receiving health or social care is able to consent. The Code of Practice (para 24.3) states: ***'Consent is the voluntary and continuing permission of a patient to be given a particular treatment, based on a sufficient knowledge of the purpose, nature, likely effects and risks of that treatment, including the likelihood of its success and any alternatives to it. Permission given under any unfair or undue pressure is not consent'.***

Why is it important to understand both Acts?

The two Acts are inextricably linked, interacting in many areas, the Code of Practice for the MHA states that '*it will be difficult for professionals involved in providing care for people with mental health problems to carry out their work (including their responsibilities under the Act) without an understanding of the key concepts in the MCA'*.

Key differences between the MHA and MCA

While the MHA is triggered when a person falls within the definition of mental disorder and meets the 'necessity test' as well as the other criteria, the trigger for the MCA is that at the material time, they lack capacity to make a particular decision within the meaning of the MCA.

39 Essex Chambers (2018) summarises the key differences as follows:

- The MCA relates to a person's functioning – that is their capacity to make a particular decision – whereas the MHA relates to a person's status, as someone diagnosed as having a mental disorder within the meaning of the Act and subject to its powers
- The MCA requires acts done or decisions made under the Act on behalf of people who lack the requisite capacity to be done or made in their best interests
  Detention under the MHA, by contrast, contains no equivalent requirement; under its provisions, an individual can be detained solely on the basis of the risk that they pose to others
- The MCA covers nearly all decision making, whereas the MHA is, to a very large degree, limited to decisions about care in hospital and medical treatment for mental disorder
- The MCA specially excludes from its ambit anyone giving a patient medical treatment for a mental disorder, or consenting to a patient being given medical treatment for a mental disorder, if the patient is, at the relevant time, detained and subject to the compulsory treatment provisions of part 4 MHA.

Advice on advance decisions (AD)

Executive Summary '*Professionals may benefit from guidance to support them with understanding advanced decisions and high risk and complex cases that they do not face very often'.*

SAR Learning Point 8: '*Advance decisions should always attract questions and seeking of legal advice in cases of self-harm and suicidal behaviour'.*

Commentary: Guidance in respect of advance decisions is set out in Chapter 9 of the Mental Capacity Act (MCA), Code of Practice (CoP) and Chapter 9 of the Mental Health Act 1983 (MHA) CoP.

Legal Framework

The Mental Capacity Act 2005 introduced a new term 'advance decisions' and provided a statutory basis for making such decisions. An advance decision is the right for somebody in law to refuse consent to a potential future treatment if they should lack capacity.

When can an advance decision be made?

People can only make an advance decision under the MCA 2005 if they are 18 or over and have the capacity to make the decision.

What makes an advance decision valid?

Chapter 9.11 of the MCA 2005 CoP states that an advance decision to refuse treatment must state precisely the following:

What treatment is to be refused

- May set out the circumstances when the refusal should apply
- Will only apply at a time when the person lacks capacity to consent to or refuse the specific treatment.

Although there is no set form, it would be useful if any written advance decision includes the following details:

- The full name of the person making the advance decision
- Their date of birth, and any distinguishing features
- Their address
- The name and contact details of their GP
- The date the document was written (or changed)
- Where a copy of the document is kept or is available
- Specific rules apply to life-sustaining treatment.

If the advance decision refuses life-sustaining treatment, it must:

- Be in writing (it can be written by a someone else or recorded in healthcare notes)
- Be signed and witnessed, and
- State clearly that the decision applies even if life is at risk.

What is an advanced decision?

The MHA CoP states that '*An advance decision means a decision to refuse specified medical treatment made in advance by a person who has the mental capacity to do so. They are a way in which people can refuse medical treatment at a time in the future when they may lack the capacity to consent to or refuse that treatment*'.

It is important to recognise that advance decisions are concerned only with refusal of medical treatment. Other advance expressions of views, wishes and feelings, often referred to as advance statements, may be about preferred medical treatment or other wishes and preferences not directly related to care, and may be about what the patient wants to happen as much as what they would prefer not to happen.

When can an advance decision be made?

People can only make an advance decision under the MCA 2005 if they are 18 or over and have the capacity to make the decision.

What makes an advance decision valid?

Chapter 9.11 of the MCA 2005 CoP states that an advance decision to refuse treatment, must state precisely what treatment is to be refused – a statement giving a general desire not to be treated is not enough, may set out the circumstances when the refusal should apply – it is helpful to include as much detail as possible will only apply at a time when the person lacks capacity to consent to or refuse the specific treatment.

Specific rules apply to life-sustaining treatment

They must say what treatment they want to refuse, and they can cancel their decision – or part of it – at any time. If the advance decision refuses life-sustaining treatment, it must:

- Be in writing (it can be written by a someone else or recorded in healthcare notes)
- Be signed and witnessed, and
- State clearly that the decision applies even if life is at risk.

What if advance decisions are made regarding treatment for mental disorder?

Advance decisions to refuse treatment for mental disorder may not apply if the person who made the advance decision is or is liable to be detained under the Mental Health Act 1983. An advance decision to refuse treatment for mental disorder can be overruled if the person is detained in hospital under the Mental Health Act 1983, when treatment could be given compulsorily under Part 4 of that Act. Advance decisions to refuse treatment for other illnesses or conditions are not affected by the fact that the person is detained in hospital under the Mental Health Act.

Capacity and advance decisions in the context of self-harm

Professionals may have particular concerns about the capacity of someone with a history of suicide attempts or suicidal thoughts who has made an advance decision. If the person is clearly suicidal, this may raise questions about their capacity to make an advance decision at the time they made it. The Mental Capacity Act states that health workers will be protected from liability for not providing treatment if they reasonably believe that a valid advance decision exists. However, it has also been argued that advance decisions to refuse treatment following episodes of suicidal behaviour raise a number of specific issues (Kapur *et al.*, 2010b). It has been suggested that clinicians should proceed especially cautiously, in view of the acute distress, ambivalence and changeability that often characterise suicidal thoughts and behaviour (Kapur *et al.*, 2010b).

Practical impact of advance decisions on health care providers

- Care plans should include information on AD
- A checklist should be used to ensure they meet the legal criteria
- Staff should receive training on the authority of AD and their status
- AD should be considered on admission.

Legal advice and the role of the Court of Protection?

Legal advice may need to be taken and ultimately The Court of Protection may make declarations as to the existence, validity and applicability of an advance decision, but it has no power to overrule a valid and applicable advance decision to refuse treatment. It is expected that the application be made by the health body responsible for that person's medical treatment. In the meantime, a patient may be given necessary treatment to stop their condition getting seriously worse. Where what is proposed is emergency medical treatment, health care professionals should not delay that treatment to look for an advance decision if there is no clear indication that one exists.

Assessment of capacity in self harm and suicide

SAR Learning Point 7: *'Mental Capacity needs careful and robust assessment where a person is presenting with severe self-harm and suicide behaviour and is refusing treatment'*.

Robust mental capacity assessments are critical in determining the approach to be taken by professionals, either to support the decision making of an adult with capacity or to intervene to protect the best interests of a person who lacks capacity. The Mental Capacity Act 2005 provides a clear framework to support the assessment of capacity in relation to specific decisions.

The capacity assessment can be a challenging piece of work, even more so in cases where the person's capacity presents a complex picture, where the risks are high in cases of self-harm, suicidal behaviour and where significant decisions are being considered around refusal of medical treatment. It is likely that situations will always require consideration of a person's capacity to make specific decisions in this context.

Why assess capacity when somebody is presenting with severe self-harm and is refusing treatment?

As per the first principle of the MCA, a person must be presumed to have mental capacity to make their own decisions. However, this principle should never be used to justify non-intervention. A judge recently pointed out '*When there is good reason for cause for concern...the presumption cannot be used to avoid taking responsibility for assessing and determining capacity.'* (See paragraph 26 of the Royal Bank of Scotland plc v AB [2020] UKEAT 0266 18 2702). Furthermore, the MCA Code of Practice states that mental capacity should be assessed when *'...the person's behaviour or circumstances cause doubt as to whether they have capacity to make a decision.'* See para 4.35, p.52.

It is important to note that before concluding that the person lacks mental capacity to make a decision, it is important to take all practicable steps to enable the person to make the decision themselves, (2nd principle of the MCA). Chapter 3 of the MCA Code of Practice gives detailed guidance on the steps to be taken to support a person with making a decision for themselves: providing relevant information, communicating in an appropriate way and making a person feel at ease.

There is a presumption of capacity enshrined in s.1(2) MCA 2005 but the presumption is not a substitute for an assessment of capacity. Where there is proper reason to think that person may lack capacity to take their own life, it is necessary to carry out a proper assessment of their capacity. Furthermore, Principle 3 of the MCA 2005, section 1(4) states that *'A person is not to be treated as unable to make a decision merely because he makes an unwise decision*.' However, Chapter 2.11 of the MCA CoP stressed that there may be cause for concern if somebody:

- Repeatedly makes unwise decisions that put them at significant risk of harm or exploitation or
- Makes a particular unwise decision that is obviously irrational or out of character.

These things do not necessarily mean that somebody lacks capacity, but there might be need for further investigation, taking into account the person's past decisions and choices. Exercising professional curiosity in such situations allows us to explore and understand what is happening for a person rather than making assumptions or accepting things at face value.

It is also important to emphasise that the determination of capacity is on the balance of probabilities (i.e. more likely than not), and the requirement is for a 'reasonable belief' (on the basis of 'reasonable steps' having been taken to establish) that the person lacks capacity to consent to acts of care and treatment being carried out. Especially in a fast-moving situation where professionals have limited information, and in circumstances where **not** taking action could endanger the person's life.

How do I know if someone lacks capacity under the MCA 2005?

A mental capacity assessment is a dynamic process of providing the relevant information to the person and then asking the person questions to assess their ability to understand, retain, use or weigh that information, and communicate their decision. A person lacks capacity in relation to a matter if, at the material time, the person is unable to make a decision for themselves in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain.

How do I assess capacity under the MCA 2005?

A person lacks capacity in relation to a matter if, at the material time, the person is unable to make a decision for themselves in relation to the matter **because** of an impairment of, or a disturbance in the functioning of, the mind or brain.

A person is 'unable to make a decision' for themselves if they are unable to do any one of the following:

- **Understand information which is relevant to the decision** to be made; for example the information that is relevant to the assessment of whether a person has the capacity to consent to medical treatment is the information going to the nature, purpose and effects of the proposed treatment, the last of these entailing information as to the benefits and risks of deciding to have or not to have the treatment, or of not making a decision at all. It is important that the information as to risks is tailored to the risks particular to that particular individual
- **Retain that information** in their mind
- **Use or weigh** that information as part of the decision-making process, or
- **Communicate their decision** (whether by talking, sign language or any other means).

How may the person's mental disorder impact on their ability to make a decision?

The case law is clear that *'It is not necessary for a person to demonstrate a capacity to understand and weigh up every detail of the respective options, but merely the salient factors.' (*Paragraphs 22 & 69 of KK v STCC [2012] EWCOP 2136. Similarly, assessors '*...must guard against imposing too high a test of capacity...because to do so would run the risk of discriminating against people suffering from a mental disability.*' (Paragraph 16 of *PH v A local authority [2011] EWCOP 1704).* Questions should therefore aim to elicit whether or not the vulnerable adult has a basic understanding and awareness of the salient issues. The relevant information is likely to be the nature, the purpose and the consequences of making that decision.

There is a large body of case law that focuses on the ability to 'use or weigh' information and the inability to do so frequently relating to the person's mental disorder. The aim is to determine whether the adult is *'...able to **employ** the relevant information in the decision-making process and determine what weight to give it relative to other information required to make the decision.*' (see para 38 of Kings College Hospital NHS Trust v C and V [2015]EWCOP 80) It is therefore necessary for the adult at risk to be able to ***apply the relevant information*** to themselves and balance the benefits and harms of the choices they are making. Another way of putting it is, can the person having understood the information, take account of it?

Examples of a person who may not be able to **apply** the relevant information include:

Obsessive Compulsive Disorder (OCD)

People with OCD may be unable to use or weigh information connected to their specific area of compulsion. They may well understand the risks of a constantly repeated action but may be unable to use (apply) this information in practice because of their severe compulsion.

Impulsive decision making

The MCA CoP (para 4.22) notes that people who are impulsive decision makers due to an impairment and disturbance of the mind or brain are likely to encounter problems with using and weighing.

Suicide and Self-Harm

A person who is suicidal could be severely depressed and may lack the capacity to consent to treatment because their depression has reduced their ability to use and weigh information. However, it should be noted that some people do make capacitated decisions to refuse life sustaining treatment and are not depressed. The important thing is to have the conversation about the nature, purpose and consequences of refusing medical treatment.

Self -neglect and refusal of services

A common area of difficulty when assessing capacity, often encountered when an adult is self-neglecting, is where the adult gives coherent answers to questions but is then unable to translate their intentions into actions due to executive dysfunction. The adult says one thing but then does something else in practice.

Executive functioning has been described as, *'...the ability to think, act, and solve problems, including the functions of the brain which help us learn new information, remember and retrieve the information we've learned in the past, and use this information to solve problems of everyday life*.'

As directed by 39 Essex Street - Carrying out and recording capacity assessments (June 2020) *' it may be necessary to gather further collateral information and ask further probing questions if there appears to be a mismatch between the adult's words and their actions.*

It would be legitimate to conclude that the adult lacks mental capacity to make a decision if they are unaware of or deny the fact that they cannot implement their stated intentions or deny that when needed they are unable to bring to mind the information required to implement a decision. However, it would only be legitimate to reach such a conclusion where there is clearly documented evidence of repeated mismatch if you conclude that the person lacks capacity to make the decision, you must explain how the deficits that you have identified – and documented – relate to the functional tests in the MCA.'

It is important to note that capacity can change over time, for example if an individual's level of consciousness changes or they are under the influence of alcohol or drugs. It is also important to note that capacity may vary according to the decision that needs to be made. An individual may have capacity to make simple everyday decisions but may lack capacity to make more complex decisions about treatment. Assessment of capacity should therefore be made on a case-by-case basis.

How does case law give a 'steer and direction' when applying the act to a person who is experiencing a mental disorder?

A paper by the MHJ (*Taking capacity seriously? Ten years of mental capacity disputes before England's Court of Protection* 'Dec 2018), a study of all reported cases where capacity was either disputed or considered by a judge of capacity highlighted the following common findings:

- Failure to consider practicable steps
- Failure to consider 'causative nexus'
- Failure to identify the elements of S3
- 'Use and weigh' most problematic area.

To 'use and weigh' information as part of the decision-making process means the person accepts the information and takes it into account. This would require them to accept and take into account any risk or other consequences. There is a large body of case law that provides examples of the meaning of 'use or weigh' information and the inability to do so frequently relating to the person's mental disorder.

- '*What is required is that the* ***person is able to employ the relevant information in the decision-making process*** *and determine what* ***weight to give it relative to other information*** *required to make the decision'.* **Kings College Hospital NHS Trust v C and V [2015] EWCOP 80**

- A man with autism and a learning disability. The judge found that he lacked capacity to make a range of decisions and stated … '*I am amply satisfied that, because of his acute anxiety that this subject generates in him, he is unable to use and weight that information as part of the decision-making process.'* ***Cheshire West and Chester v PWK [2019] EWCOP 57***

- An intelligent and articulated person may still be found to lack capacity because they cannot use or weigh information. This challenge was highlighted in **NCC v PB &TB [2014] EWCOP 14** about a woman with long term mental health problems and her capacity to live with a person who posed many risks to her. The judge stated to the assessing psychiatrist that: '*his emphasis on PB's sophisticated, dextrous use of language, which was not in dispute, caused him to lose focus on the issue of using and weighing the information.'*

- **Obsessive Compulsive Disorder (OCD)**
  People with OCD may be unable to use or weigh information connected to their specific area of compulsion. They may well understand the risks of a constantly repeated action but may be unable to use (apply) this information in practice because of their severe compulsion.

- **Impulsive decision making**
  The MCA CoP (para 4.22) notes that people who are impulsive decision makers due to an impairment and disturbance of the mind or brain are likely to encounter problems with using and weighing.

- **Suicide and Self-Harm**
  A person who is suicidal could be severely depressed and may lack the capacity to consent to treatment because their depression has reduced their ability to use and weigh information. However, it should be noted that some people do make capacitated decisions to refuse life sustaining treatment and are not depressed. The important thing is to have the conversation about the nature, purpose and consequences of refusing medical treatment.

Common challenges in practice

a) What if someone refuses to be assessed?

It is important to think of ways in which to seek to persuade the person to take part, for instance on the basis that helping the assessor will help them. It is often helpful to liaise with others about what alternative strategies might help.

The MCA CoP Para 4.59 'Nobody can be forced to undergo an assessment of capacity. If someone refuses to open the door to their home, it cannot be forced. If there are serious worries about the person's mental health, it may be possible to get a warrant to force entry and assess the person for treatment in hospital – but the situation must meet the requirements of the Mental Health Act 1983 (section 135).'

Serious concerns? As a last resort an application could be made the Court of Protection for an interim order under s.48 of the MCA. This may need to be considered when those concerned with the adult's circumstances have been unable to complete a capacity assessment. This may be because they have been prevented by a third party or because the person refuses to be assessed. In such circumstances, it will always be necessary to make clear in a supporting witness statement why the person or body bringing the application has reasonable grounds to believe that the adult may lack the relevant capacity. One of the first steps that the Court will then take is to bring about a proper capacity assessment; that capacity assessment will then determine whether or not it has jurisdiction to take further steps in relation to the adult.

b) Executive functioning?

As directed by the MCA 39 Essex street guide: *'You can legitimately conclude that a person lacks capacity to make a decision if they cannot understand or use/weigh the fact that they cannot implement in practice what they say in assessment they will do, or (if relevant) that when needed, they are unable to bring to mind the information needed to implement a decision;*
BUT
You can only reach such a finding where there is clearly documented evidence of repeated mismatch. This means, in consequence, it is very unlikely ever to be right to reach a conclusion that the person lacked capacity for this reason on the basis of one assessment alone,
AND
If you conclude that the person lacks capacity to make the decision, you must explain how the deficits that you have identified – and documented – relate to the functional tests in the MCA.'

c) Fluctuating Capacity

Some people's ability to make decisions fluctuates because of the nature of a condition that they have. This fluctuation can take place either over a matter of days or weeks (for instance where a person has bipolar disorder) or over the course of the day. If it is a one-off decision, it may be possible to put it off until the impact of the person's condition upon their decision-making abilities has diminished. Some decisions are not one-off and need to be repeated over a period of time. Examples include the management of a physical health condition which requires a multitude of 'micro-decisions' over the course of each day. Although capacity is time-specific, in such a case, it will usually be appropriate to take a broad view as to the 'material time' during which the person must be able to take the decisions in question. Decision making should be kept under review.

d) Recording an assessment of capacity when the risks are significant

If you have proper reason to think that the person may lack capacity to take a relevant decision, especially if the consequence of what they are wanting to do is likely to lead to serious consequences for them, it would be simply inadequate for you simply to record (for instance) *'as there is a presumption of capacity, [X] decision was the person's choice.'* Indeed, the more serious the issue, the more one should document the risks that have been discussed with P and the reasons why it is considered that P is able and willing to take those risks.

The MHA CoP states (para13.22):

'Decision-makers should ensure that where a capacity assessment is undertaken, this is recorded in the individual's care and treatment record. As well as the outcome of the test, the following should be recorded:

- The specific decision for which capacity was assessed
- The salient points that the individual needs to understand and comprehend and the information that was presented to the individual in relation to the decision
- The steps taken to promote the individual's ability to decide themselves
- How the information was given in the most effective way to communicate with the individual
- How the diagnostic test was assessed, and how the assessor reached their conclusions, and
- How the functional test was undertaken, and how the assessor reached their conclusions.'

Our decision making should be lawful, just and reasonable. Defensible decision-making means recording a clear rationale for all the decisions made and the discussions that led to the decisions, including reference to relevant legislation such as the Mental Capacity Act which 'scaffolds' our professional decision making.