This guidance is designed to be read in the specific context of self neglect cases. As such it presupposes a baseline level of knowledge in regard to the basic tenets, principles, and working practices associated with the Mental Capacity Act (“the Act”).

**When should I assess Mental Capacity ?**

Principle 1(2) of the Act states that *“A person must be assumed to have capacity unless it is established that (s)he lacks capacity.”* Effectively this means that the onus is upon the professional questioning the individual’s mental capacity to prove that they LACK capacity , rather than the person having to prove that they HAVE capacity. Professionals may not move onto make decisions for their patient / service user without first providing evidence that the person LACKS capacity. Additionally professionals are not exempt from having to seek that evidence where it is required.

*Learning from SARS: A report for the London Safeguarding Adults Board (July 2017)*comments on *“the impact of practitioners making an insufficiently tested presumption of capacity, sometimes in relation to quite significant decisions on medical treatment or on self care, because capacity was assumed, missed opportunities to balance choice and independence with the need for protection and safety.”*

Principle 1(3) of the Act states “*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.”* This is to say that considerations about capacity should arise from active attempts to support the person’s own decision-making. The degree to which steps should be considered ‘practicable’ or not will depend on the urgency and level of risk in any given situation. Suffice to say that many self neglect situations present or develop over a period of time so there is often ample opportunity for this. Examples could include; i) arranging members of the fire service to attend and discuss risks with the person, ii) Ensuring that relevant information is shared by team members who have developed a trust and rapport with the person, iii) Recording the conversation on the persons smartphone so that they can access it later.

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| **Don’t fall into the trap of failing to assess the person’s capacity where there are clear concerns and doubts. Do start by assuming that they can make the decision and trying to help them with it.** |

**What is the decision to be made ?**

Consideration of capacity is decision specific and must be assessed in this context. This means that capacity must not be expressed in relation to the person generally (e.g. The person has / lacks capacity in regard to *all decisions*) but in relation to a specific decision at a specific time.

Whilst it is important to recognise the ‘decision specific’ nature of the Act in reality individual’s lives are often complicated and decisions they make inter-connected. For example an argument can be made that a person’s alcohol misuse (often evident in self neglect cases) is inextricably linked to their care and support needs. Therefore, rather than consider capacity to drink alcohol as a stand alone issue it could be subsumed into the *relevant information* of a residence & care decision.

In a case involving alcohol misuse (***London Borough of Tower Hamlets v PB [2020} EWCOP 34)*** Hayden J explicitly deals with this issue stating *“The (capacity) question is not whether PB will drink to excess: the question is whether he lacks capacity to make decisions about his residence and care. The question of whether he will drink to excess is part of that.”*

Recent case law also directs capacity assessors to consider if the decision should be considered as a *micro* or ‘one off’ decision or a *macro* or ‘repeated’ decisions. Determination of this will need to be considered on a case by case basis. Within a self neglect context however a *macro* approach will often be a relevant perspective to take in that it can involve the rejection of multiple care / support interventions over an extended period of time.

Newton J in ***Royal Borough of Greenwich v CDM [2019] EWCOP 32*** held that (in this particular case) it was appropriate to consider the many individual decisions regarding insulin administration as a whole stating that *“Diabetes management is not a single decision but a coherent series of decisions over time.”* Thissame principle may be applied to the acceptance (or not) of support for the individuals assessed care needs at their place of residence. (e.g. ongoing support in regard to maintaining housing, nutrition, medication management, medical treatment etc)

In cases such as these a *longitudinal* approach to assessing capacity will be required such as that suggested in ***Sunderland City Council v AS and Others [2020] EWCOP 13.*** Prior to recent case law guidance the determination of capacity was often based solely on an interview with the person. Now in the circumstances discussed this should be supplemented and checked against ‘real world’ sources of information (i.e. digital and paper records, interviews with interested parties, multiple interviews with the person). This also supports the second principle of the Act referred to at 1.3 above. Whilst simultaneously supporting the person to make the decision professional assessment is now based on a ‘video rather than a picture’

Often professionals start to consider the issue of capacity without a clear idea of the decision that they are considering. It is essential to first consider not only *‘what the decision is’* but also *‘how the decision should be framed.’* All future work and intervention flows from this point. If the formulation of the decision is flawed then it follows that subsequent interventions and professional decision making could also be.

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| **What is my professional involvement with the person and what am I trying to achieve by assessing capacity ? Should I consider the decision as an individual one or do I need to ‘zoom out’ and consider the situation as a series of linked decisions ?** |

**Who is the Capacity Assessor and Decision Maker ?**

A major barrier to the implementation of the MCA are disagreements as to whose responsibility (service or professional) it is to undertake the assessment. In regard to micro decisions or consent to a particular intervention then the issue is more straightforward.

*If a doctor or healthcare professional proposes treatment or an examination, they must assess the person’s capacity to consent”. MCA Code of Practice 4.40*

*“…the final decision about a person’s capacity must be made by the person intending to make the decision or carry out the action on behalf of the person who lacks capacity …”* MCA Code of Practice 4.44

It may be less clear in the context of i) macro decisions, ii) complex decisions or iii) multiple professional involvements who should be responsible for taking the action on behalf of the person. In these circumstances multidisciplinary team members should agree amongst themselves as to who the most appropriate professional would be to take on the assessment. In cases where there is dispute then a meeting may have to be arranged. This with the caveat that it should occur in a timely fashion and not increase risk for the person. Often where there is dispute or uncertainty then a quicker solution is to carry out a joint assessment between services or professionals.

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| **If I don’t assess the person’s capacity who will? How can I climb out of my professional silo (or encourage others to climb out of theirs)? How can we work together to make sure this person’s autonomy and safety is protected ?** |

**How do I assess Mental Capacity?**

It is important to note that the MCA Code of Practice (2005) is now incorrect in respect of the order in which the 2 stage capacity assessment should be undertaken. Case law now demonstrates that assessors should;

i. First consider if the person is able to understand, retain, use or weigh, and communicate the relevant information

ii. Then consider if this is ***because of*** a mental impairment

*Can the person understand the relevant information ?* Case law now sets out where the relevant information for particular domains of decision making are detailed. Case law alsoinforms assessors that the relevant information detailed in these cases must be adapted to the individual circumstances and the facts of the person being considered. They should be viewed as ‘guidelines rather than tramlines.’ Assessment here should include, i) detailing of the relevant information, ii) some verbatim content of the discussion iii) reference to other sources of information and iv) analysis of the discussion.

*Can the person retain the relevant information ?* Section 3(3) of the MCA states *“The fact that a person is able to retain the information relevant to a decision for a short period only does not prevent him from being regarded as able to make the decision.”* Adhering to this is relatively straightforward in the context of micro decisions where the capacity assessment is based on a single interview where support can be given in the form of *“notebooks, photographs, posters, videos and voice recorders can help people record and retain information.”* It is more useful in the context of macro decisions to consider if the person can retain the relevant information ‘at the material time’ the decisions need to be made. (e.g. when deciding about admitting carers entry to their property, to smoke a cigarette in bed, or to receive treatment for wound care.)

The issue of fluctuating capacity can prove challenging here. In these circumstances it may be useful to consider the following points; i) Viewing the matter as fluctuating *cognition* in the first incidence may be helpful*.* Is the person aware of their fluctuating cognition and the impact that it will have on their decision making at the time they are at their most impaired ? When assessed at their most alert they were able / unable to retain relevant information in regard to their fluctuating cognitive state and its impact upon their safety ? ii) If the person is deemed to experience genuine fluctuating capacity then considering the proportion of time they are capacitous to when they are incapcaitous can be useful. Case law suggests that it may be possible to progress with a finding of incapacity where the person is more often incapacitous than not (& vice versa).

*Can the person use or weigh the relevant information ?* When assessing capacity it is essential that the person under assessment is made aware of the actual options that are available.

*“Capacity assessors should not start with a blank canvas. The person under evaluation must be presented with detailed options so that their capacity to weigh up those options can be fairly assessed".* CC v KK and STCC [2012] EWHC 2136, (COP) [2012] COPLR 627

An example in a self neglect context might be asking the person to detail the pros and cons of; a) care in a nursing home where nurses can monitor nutrition and pressure areas over a 24 hr period alongside ensuring a hygienic uncluttered home environment vs b) care in their own home where monitoring of nutrition and pressure areas will be by carers twice a day. Carers will be unable to do little in the way of maintaining the home environment.

Asking individuals to detail the pros and cons of options can often be insufficient in respect of evidence. In self neglect contexts the person’s responses may be impacted on by denial about their living situation, previous negative experience of services, a lack of trust, or a fear that an admission of problems will be used as ‘evidence’ against them. Attempting to separate out these elements from a genuine lack of capacity can be challenging for professionals. In such situations it can be helpful to acknowledge the above issues, ask the person *what others* are worried about, and ask how they would manage the risk. Asking what others are concerned about provides a useful alternative means of determining the use or weigh element. It can demonstrate that the person is able to see things from an alternative perspective (in order to have capacity a person must first be able to hold different options or viewpoints in their mind) and allow them opportunity to forward alternative views / strategies.

An additional complication in self neglect cases can arise as a result of individuals who experience problems with their **executive function**. This can be present in conditions such as traumatic brain injury, acquired brain injury (stroke), and certain dementias (Frontotemporal, Korsikoffs). Individuals with these conditions may show minimal impairment in regard to their global cognitive abilities but struggle with higher level executive processes. Often this means difficulties with impulse control, emotional regulation, initiation, planning, organising, or rigidity of thought. Professionals will often note that these individuals can ‘talk the talk but not walk the walk’. In such cases a ‘tell me – show me’ approach can often be useful. For instance.‘I can see that you do not want to get rid of your (hoarded) possessions but show me how you or carers might access the kitchen to prepare food and drink?’

Care must be taken when looking at decisions through a *macro* or *longitudinal* lens that the 3rd principle of the MCA (*“A person is not to be treated as unable to make a decision merely because he makes an unwise decision”)* is not breached. Current statute and law does not currently insist that individuals must carry out the decisions that they have verbalised. Professionals must remain alert to the fact that individuals may change their minds at the point of making a decision or deliberately mislead professionals in order to temporarily relieve themselves of their input. Conversely a mismatch between what a person says and what a person does or a change to their usual behaviour may provide evidence that a mental impairment is adversely affecting their decision making and mental capacity.

Court of Protection case law **(GM; FP v GM and A Health Board (2011) EWHC 2778 (COP) & Cardiff Council v Peggy Ross (2011) COP 28/10/11 12063905)** has highlighted circumstances where professionals have given more weight to physical safety in MCA considerations. A common error in such circumstances is that professionals equate the individual’s disagreement with them in regard to the risk with a lack of capacity. As is stated in ***Macur in LBL v RYJ { 2010 } EWHC 2665 (COP)*** *“assessors must recognise that different individuals may give weight to different factors.”* Understanding the context of the person’s life is essential here in understanding why their reasoning may differ and why they may be placing a greater weight on other factors than professionals.

A range of terms relating to executive function and dysfunction such as executive capacity and frontal lobe paradox are now in common usage when exploring the difficulties and tensions that professionals face in practice. It is important to note however that these terms do not exist either within the Act itself or Code of Practice. Case law warns against using descriptions and definitions such as these formulated in clinical practice as ‘equivalents’ to the capacity test specified in the MCA. What is required is a thorough consideration of the individual’s ability to use and weigh the relevant information ‘at the material time’.

*Can the person communicate the relevant information ?* This element of the test was originally designed to apply to very few people, for example those in a coma or locked in syndrome. Most individuals who are self neglecting will have the ability to express their views and wishes in regard to their care, this often being the point of contention with professionals and services. If a person is able to express a general view on decisions either verbally or thorough other means (typing, behaviour, facial expression) then they will meet this element.

*What is the Mental Impairment?* In order to come to a conclusion that a person LACKS capacity then the person must have a Mental Impairment as defined in the MCA (“*a disturbance in the functioning of the mind or brain”).* Examples of chronic impairments might include Dementia and Learning Disabilities. Examples of temporary impairments might include alcohol / drug intoxication and delirium brought about by infection.Case law has continued to define mental impairment broadly. For example, agoraphobia and anxiety.

Case law has also determined that the mental impairment does not necessarily have to be ‘diagnosed’ by a medic or in official classifications such as the ICD10 or DSM-5. This can be useful in the early stages of a self neglect cases where only possible symptoms are present and there are difficulties in securing the engagement of the person or relevant professionals. It enables professionals to progress on the grounds of a working diagnosis or suspicion. Case law has alsohighlighted that a formal diagnosis or a medical opinion will offer stronger evidence which may be required if more restrictive interventions are thought to be necessary or the nature of the Mental Impairment is thought to have a greater bearing on the person’s capacity state.

*Is there a* ***Causative Nexus*** *between the inability to make a decision and* *the Mental Impairment ?* It is insufficient to merely state that the person has a mental impairment. The person must be unable to make the decision *because of* the mental impairment. If the primary reason for their impaired decision making is down to factors such as; i) denial about living circumstances and care needs, ii) indecision due to having no good options, iii) lack of experience in regard to the decision then it is not possible to state that they LACK capacity.

The type of mental impairment is particularly important in self neglect cases where there are suspicions about an impairment of executive function. As stated earlier certain mental impairments are associated with frontal lobe damage and executive dysfunction. In these cases the stronger evidence in the form of a medical opinion or formal diagnosis should be sought as the case progress. An example statement here may be *‘P’s GP is of the view that he suffers with a fronto-temporal dementia of which impairment of executive functioning is a recognised symptom. It is P’s fronto-temporal dementia which is causing his inability to make a decision in regard to where he lives for his care and support. This includes the care he receives for epilepsy monitoring and medication.’*

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| **I now start off by discussing the decision with the person and then afterwards decide if the lack of capacity is due to a mental impairment. I don’t necessarily need a medic to confirm the mental impairment but it will be required where professionals think more severe restrictions are required or there are concerns about their executive functioning. If I have ‘zoomed out’ then my assessment of capacity needs to be much more than a one off chat with the person. Finally have I made clear what the ‘options on the table’ actually are for the person.** |

**How should Best Interests be considered ?**

If the self neglecting individual is deemed to LACK capacity then professionals can continue to then make decisions with the person in their Best Interests. The Act states that those considering best interests must consider 6(a) *“the person's past and present wishes and feelings …”* and 6(b) *“the beliefs and values that would be likely to influence his decision if he had capacity”.* This is further developed in ***Wye Valley NHS Trust v Mr B [2015] EWCOP 60*** which reminds practitioners that capacity is not a ‘cliff edge’. Under Best Interests we must have regard to the person’s views and wishes and that the closer the person is to having capacity the more weight their views should be given.

The Act also compels practitioners to take into account the views of interested parties (other family members, friends and professionals). When consulting with others it is important to ask them *‘what do you think the person under assessment would have wanted?’* in addition to soliciting their own views. Information gathered from these exchanges can also be used to inform future capacity assessment. In a self neglect context making Best Interests decisions has difficulties particularly if the decision reached is contrary to the person’s wishes. The main challenge at play here is the presence or not of a 3rd party to carry out actions in that person’s Best Interests. If the person is in care then this issue is less acute as there are individuals present to place restrictions and / or carry out actions on the person’s behalf. For instance in respect of dealing with a smoking / fire risk carers in a residential home could limit access to an incapacitated person’s lighter under a Best Interests decision.

Where the person lives in their own home and has intermittent care or no care at all the issue can prove particularly challenging. Guidance offered at the beginning of this document may be useful here in regard to formulating the decision correctly at the start. If the person is refusing to take vital medication in their own home an assessment simply around this domain may be of limited use (if they LACK capacity who is going to administer this on their behalf?). Integrating this into a wider “Can the person make decisions in regard to where they reside for their care and support” decision may be of more use.

Using the broader residence and care formulation is often useful in self neglect cases but it can bring practitioners to a rather stark choice of options between the person staying in their own home vs a removal to a care home or other place of safety. Whilst considering the matter in such terms can seem harsh it may also help to draw out the actual risks at play in the situation and focus professional input on a solution. It is important to note however that outside of emergency medical situations a decision to move an objecting individual from their own home into care will require legal input to consider an application to the Court of Protection.

On occasion individuals may have granted legal decision making authority to a trusted other through Lasting Power of Attorney arrangements. It is important to check the validity of any individual claiming to have LPA and this can be done by asking to see their documents (which should be stamped with an OPG mark) or searching the [Office of the Public Guardian Register](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1116079/opg100-find-out-if-registered-attorney-or-deputy_2022.pdf) .

Lasting Power of Attorney arrangements are granted in relation to i) property and affairs and ii) health and welfare. Attorneys may possess one or both. Examples of decisions that a property and affairs attorney might make in a self neglect context include; i) authorising payment to carry out a deep clean on a property, ii) paying for assessed care where that individual is liable for care costs. Examples of decisions that a health and welfare attorney might make in a self neglect context include; i) deciding on the provision of domiciliary care / choosing between care homes or ii) treatment for diabetes care. It is important to note that LPA’s (who are often lay people, family & friends) have similar responsibilities to professionals. They do not consent on behalf of the person but make a Best Interests decision on that person’s behalf. They must also take into account the views of the person and other interested parties following the ‘Best Interest checklist’ detailed in the MCA Code of Practice. LPA’s like professionals can only choose between the available options and can not demand treatment that is not clinically indicated.

Health & Welfare LPA’s cannot authorise a deprivation of liberty. As with professional decision makers legal advice should be sought around any attempt to remove an objecting person from their own home. Similarly Property and Affairs Attorneys should not use their powers in regard to the property & affairs to undermine health and welfare decisions where they do not have that authority. E.g. looking to sell property when a move into care has not yet been agreed. These type of situations will require legal advice and / or referral to the [OPG Safeguarding Team via an OPG130](https://www.gov.uk/guidance/report-a-concern) .

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| **Best Interests isn’t about what I want or what family want. It is an attempt to look at the situation from the incapacitated person’s perspective. When making decisions about Best Interests we need to think about who will carry out any of the actions and some of the ‘real world’ difficulties that may be faced. If the person lives on their own or with little support who is actually going to carry out any Best Interests actions ?** |

**The interface between Safeguarding Adults process and the MCA**

It is important to note that a Safeguarding Adults referral on the basis of self neglect is not dependent on the person’s capacity status. Under the 2014 Care Act ‘self neglect’ falls under the definition of causes that should prompt professionals to make safeguarding enquiries. If the individual; (a) has care and support needs, (b) is experiencing or at risk of experiencing abuse or neglect and (c) is unable to protect themselves as a result of those needs then a referral should be made even where they are deemed to HAVE mental capacity.

In situations where the self neglecting individual is deemed to LACK capacity in the relevant domain(s) then input is likely to involve identifying opportunities for intervention and risk management between partner agencies alongside Best Interests decision making either at the local or Court or Protection level. In situations where the individual is deemed to HAVE capacity in the relevant domain(s) then Best Interests decision making and Court of Protection oversight become unavailable. However particularly contentious cases can be considered under the inherent jurisdiction of the High Court. This however is usually restricted to short-term restrictions to remove the influence of coercive elements in the person’s life.

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| **Even where a person is deemed to have capacity I need to consider a referral to the Local Authority**  **for Self Neglect.** |

The following SSAB resource : *Adults who Self Neglect Flowchart* is a useful adjunct to this guidance

<https://ssab.safeguardingsomerset.org.uk/wp-content/uploads/SSAB-Self-Neglect-Practice-Guidance-Appendix-3-Agreed-24-09-2019.pdf>