

## To assume, or not to assume (capacity)?

I was asked an interesting question the other day whilst consulting a senior professional about the application of the Mental Capacity Act 2005 (the Act); they asked me "Do you ever assess the capacity of people who agree with the decision maker?".

I was initially unsure what was being implied but having clarified the point being made that that 'we' (professionals) may be less inclined to assess an individual's mental capacity if they agree with the decision being made; therefore, assumably relying on Principle 1 of the Act at Section 1(2) – **'A person must be assumed to have capacity unless it is established that he lacks capacity'**.

This made me think, and in case my thoughts may be of use to others I have set them out here. I must admit I have not conducted a literature review on this topic owing to time constraints on my end; therefore, these views are simply my musings with minimal academic or research-based foundations.

So, is P's compliance sufficient to rely on the 'assumption of capacity'? Is this the correct interpretation of the assumption of capacity in the Act? I suggest not to both questions.

The wording of the statute raises an interesting dichotomy; it states you **must** assume capacity unless it is assessed [therefore determined] otherwise... so what about the triggers which instigate an assessment, and the timeframe in which the assessment is being conducted? We see here a catch-22, do we not?

I listened to an interesting discussion (Shedinar)<sup>1</sup> between Alex Ruck-Keene, Dr Scott Kim and Isabel Astrachan concerning their September 2023 collaborative paper published in the Journal of Medical Ethics on this exact topic.<sup>2</sup> The discussions surrounded when professionals should "suspend the presumption of capacity" to allow for an assessment to establish if P lacks capacity - therefore engaging section 2 [and forward] of the Act. Specific to P's circumstances, if there are identifiers or triggers that they 'may' have difficulty making the specific decision at hand should not be ignored and therefore a reliance on the assumption of capacity is not correct in this context. There is no clear checklist of indicators, but they suggest, and I strongly agree that these must be specific to P's circumstance and the decision needing to be made.

My thoughts went to that surely just because P is agreeing with the decision does not mean there are no indicators to assess their capacity? Are practitioners being lazy in these cases relying on the assumption? It is intentional to avoid the complications of the Act, or is it an unintentional misinterpretation? I hope the latter.

The Act's 2007 Code of Practice (4.35) states several reasons why people may question a person's capacity; including P's behaviour or circumstance causing doubt as to their decision-making ability, someone is concerned about their capacity, and they have been diagnosed with an impairment or disturbance that affects the way their mind or brain works and incapacity has been shown in other life decisions. I am not comfortable with the last two underlined points in the Code. To my mind, having a confirmed impairment is perhaps putting the 'cart before the horse', and

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<sup>1</sup> <https://www.mentalcapacitylawandpolicy.org.uk/questioning-our-presumptions-about-the-presumption-of-capacity-in-conversation-with-isabel-astrachan-and-dr-scott-kim/>

<sup>2</sup> <https://jme.bmj.com/content/early/2023/09/25/jme-2023-109199.info>

this is likely here as the Code has not been brought up to date with the current approach of first testing capacity using the functional test (Section 3(1)) before establishing if a failed functional test results from a diagnostic causation, as set out nowhere so clearly as in the case of JB [2021] UKSC 52. I am also not comfortable with the use of the word “diagnosed”; as we know the diagnostic test does not necessitate a formal diagnosis. Furthermore, the statement concerning ‘other life choices’ does not sit comfortably with me concerning the decision-specific nature of how the Act should be applied.

The draft Act’s Code of Practice (although we are still awaiting its implementation before it can/should be relied upon), helpfully inserts the following statement at 2.6: - *“Assuming capacity should not be used as a reason for not assessing capacity in relation to a decision. There should always be a proper assessment where there are doubts about a person’s capacity to make a decision”*.

Indicators of incapacity, or triggers to assess capacity (and therefore ‘suspend the assumption of capacity’ as Alex R-K eloquently puts it), must be specific to the individual’s situation and the decision being considered for them. I agree there is no one-size-fits-all approach – like that of making best interest decisions for people when they are deemed to lack capacity. However, when training health and social care professionals, I use the following generalised examples of potential triggers. Therefore if present, these may result in an incorrect assumption of capacity if the capacity test is not carried out: -

- P behaves in a way which indicates they may lack capacity,
- P’s circumstances suggest they may lack capacity,
- Others raise legitimate concerns about P’s capacity,
- The decision which P needs to make is complex,
- There have been previous capacity determinations that P lacked capacity to make this specific decision,
- Any other reasonable justification that P may fail the functional test because of an impairment of, or disturbance in the function of their mind or brain.

The argument of paternalism arises, but to argue paternalistic practice by ignoring indicators of incapacity is surely, inherently paternalistic, as you are then not engaging the provisions of the Act set out to guide the assessment process, and subsequently make decisions for those who cannot do this themselves, resulting in the decision maker deciding without the safeguards of the respective legislation (as in my first example when P agrees with them). I have, as an individual’s IMCA, recently been told (by a regional lead psychiatrist) that we must rely on the presumption of capacity, so *“I do not need to comply with the Court of Protection Order direction to assess capacity concerning the use of covert medication administration for my patient”* – that’s another story for another day, but it contextually supports my viewpoint here about paternalism and incorrect reliance on Principle 1 of the Act.

To my mind, it boils down to the same balance which underpins all human rights-based practice: how far should ‘the state’ intervene with individuals’ rights and freedoms?

The right to make our own decisions is, and must be, well protected; after all, is this inalienable right not part of what makes us human beings? The consent principle (or right to self-determination/autonomy) is protected as a common law concept for this reason. I don’t want any state organisation telling me I cannot do something which is within the purview of my rights

(drinking alcohol, smoking, etc.). It's about my right to my private life, my right for the state not to arbitrarily interfere with my personal choices (although tempted, I won't get into Principle 3 here). To my mind this is a fundamental protection set out within the ECHR under its negative obligations concerning Article 8 right to, inter alia, a private life.

Balanced with this, we have the positive obligations of the state to protect individuals when it recognises that a right is being infringed, or more relevant for this topic, when an individual is at risk of harm by their [perhaps incapacious] actions, and how far the state can and should go to make 'the decision for them'. Hypothetically, if I were to lose capacity and attempted to make a decision which, if I later regained capacity I would regret and assert to be the wrong decision, I would be much more inclined for my capacity to be assessed and a decision to be made in my best interests by those with the knowledge and skills to do so correctly.

There is also surely an argument that to not protect an individual with 'potentially' impaired decision-making, is to disadvantage or place at risk a 'disabled' person – potentially conflicting with the provisions of the Equality Act 2010 and Article 14 of the ECHR.

It's a delicate and sometimes difficult balance between respecting autonomy and protecting vulnerability...

In the aforementioned 'Shedinar', Alex R-K asked Dr Kim how Principle 1 could be rewritten to reduce this incorrect professional reliance on 'the assumption' when there are indicators of incapacity, and I thoroughly loved Dr Kim's response; he proposed the wording of Section 1(2) be amended to state something to the effect of: - **'A person must be assumed to have capacity unless there is a justifiable reason to assess it and it is then established that he lacks capacity'**. How much clearer would that be in this context?

I talk about this a lot when running human rights, and mental capacity training for health and local authority organisations, and it's something I have a particular interest in following my LLM research project on care home residents and their ECHR Article 8 rights during the Government Covid-19 visiting restrictions, and my experiences in independent social work and advocacy practice. Therefore, I would love to hear other people's thoughts on this.

Written by,



**Kane Barnacle** LLM, BA (Hons), PG (Cert)

[Best Interest Services Ltd]

Independent Social Worker  
Expert Witness  
Consultant Advocate