# Functional Assessment of Capacity - Transforming Reductive Capacity Assessments?

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# Committee on the Rights of Persons with Disabilities: Criticisms

- Linking of mental capacity to legal capacity…that mental capacity is not "*an objective, scientific and naturally occurring phenomenon…[but]…is contingent on social and political contexts, as are the disciplines, professions and practices which play a dominant role in assessing mental capacity*".

- Functional approach to capacity "*presumes to be able to accurately assess the inner-workings of the human mind and, when the person does not pass the assessment, it then denies…the right to equal recognition before the law*".

# Problems with Functional Capacity

- Reduces complexity of human nature and decision making to a simple 'functional formula'.
- The importance of noncognitive factors such as values and emotions are insufficiently recognised by a cognitive functional model.
- Statutory cognitive abilities – in particular, to understand and to use or weigh information - are difficult to operationalise and apply.
- What threshold? Hazards of the sliding scale
- Clinician assessments of capacity are relatively arbitrary in many cases and may be contaminated by clinicians' personal values and biases
- Other cognitive abilities – in particular lack of insight and executive dysfunction – invoked but so poorly defined that they can be misused to penalise disagreement about goals or values

# Low Agreement between Experts

- Competence judgments are value laden, frequently subjective and inconsistent (Brindle & Holmes Age Ageing 2005)

- Marson et al JAGS 1997
  - 29 patients with mild Alzheimer's disease
  - Videotaped standardised capacity interviews
  - Rated by 2 neurologists, 1 psychiatrist and 2 geriatricians
  - Agreement in judgments of capacity no better than chance

- Standardised capacity interviews and assessments?
  - Improve inter-rater reliability but poor inter-instrument agreement even when based on the same legal standard (Gurrera et al, Am J Ger Psych 2007)

# Sliding scale for threshold?

- Low threshold when P accepting a treatment very likely to benefit & low risk of harm; higher threshold if refusing that treatment
- Re M.B. (Medical Treatment), Butler-Sloss L.J.: “*The graver the consequences of the decision, commensurately greater the level of competence is required to take the decision …*”
- Judging capacity by whether decision is a ‘good’ one or not?
  - *‘To understand a proposed treatment well enough to consent to it is to understand the consequences of a refusal. If the consequences of a refusal are understood well enough to consent to the alternative then the refusal must also be competent’* (Harris JME 2003).
  - *‘…where gravity is extreme, doctors and courts allow their dislike of what a patient proposes to outweigh their desire to see that person’s wishes respected, whatever the patient’s capacity’.* (Buchanan J Roy Soc Med 2004)

# Elements of capacity ....

- Communicate a decision (by any means)
- Retain information long enough to make a voluntary choice.
- Understand information relevant to the decision.
- Use or weigh information as part of the process of making the decision

Complexity
(Trying to define/ Trying to pass)

Reliability of assessment

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# Taking capacity seriously? Ten years of mental capacity disputes before England's Court of Protection

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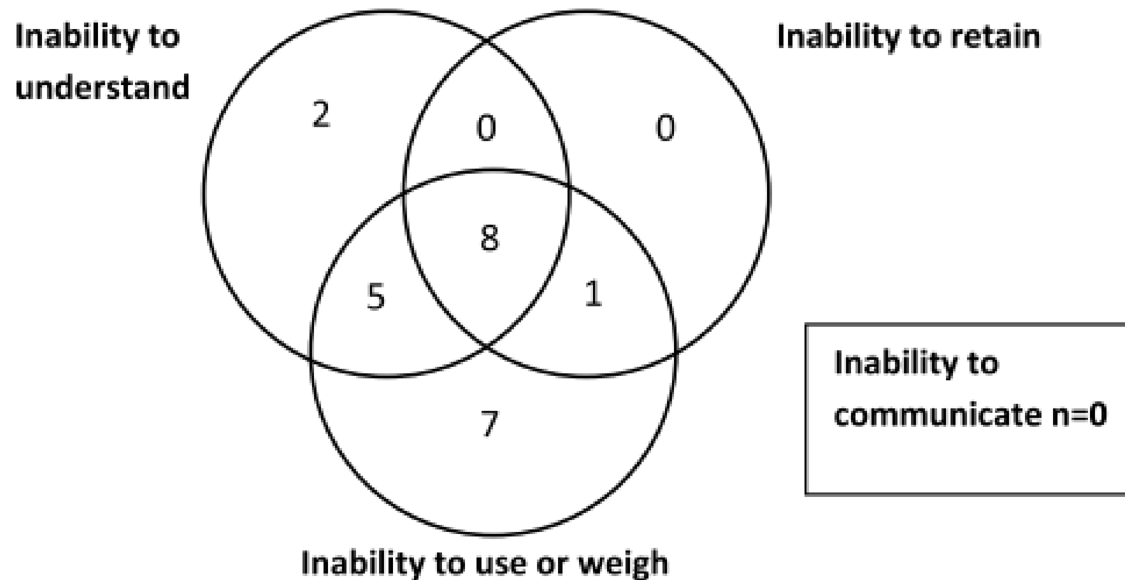



**Fig. 2.** Distribution of functional inabilities cited by judge for P's lack of capacity[1].

# Implicit/Embedded cognitive abilities

- ‘Appreciation’, ‘insight’, ‘executive/ frontal brain function’
- Feature in professional reports regarding capacity
- Unclear how they map onto statutory criteria.
- Lack of clarity means they can be used to medicalise dissent and to widen the net of capacity assessments.

# Appreciation – the missing concept?

- Ability to acknowledge, or appreciate or believe, the personal relevance of relevant information.
- Includes 'patently false beliefs, often as a result of denial, distortion or delusions, that what they are told is not true for them (Grisso, Applebaum)
- Overlap with Understanding and Using and Weighing
- Appreciating information doesn't mean one needs to attach weight to that information in decision making
- Need to avoid penalising people who have unusual beliefs. Thorpe J. in *Re C (adult: refusal of medical treatment) "Although his general capacity is impaired by schizophrenia … I am satisfied that he has understood and retained the relevant treatment information, that <u>in his own way he believes it</u>"*

# (Lack of) Insight

- Insight is the clinical concept that is most closely associated with the legal concept of capacity... (Owen 2009)
- Lack of insight is a term that is easier to use than to define (Fulford, 2004)
- The insight concept remains legally ill-defined and its frequent use as an extra-legislative criterion in determining psychiatric detention threatens the purpose of legally safeguarding the liberty interests of patients. Diesfeld (2003)
- In some cases, lack of insight synonymous with lack of appreciation of information: denying the undeniable

- Neurology: 'anosognosia' – denial of illness. e.g. Anton's syndrome - a stroke leads to total blindness which is totally denied by the person.

- Initially dichotomous concept.  Now multidimensional, on a continuum

- Vernacular disguised as technical, scientific concept

"Tis but a scratch. Had worse."

"Look, you stupid bastard, you've got no arms left"

"Just a flesh wound"

# DANGEROUS LIAISONS? PSYCHIATRY AND LAW IN THE COURT OF PROTECTION— EXPERT DISCOURSES OF 'INSIGHT' (AND 'COMPLIANCE')

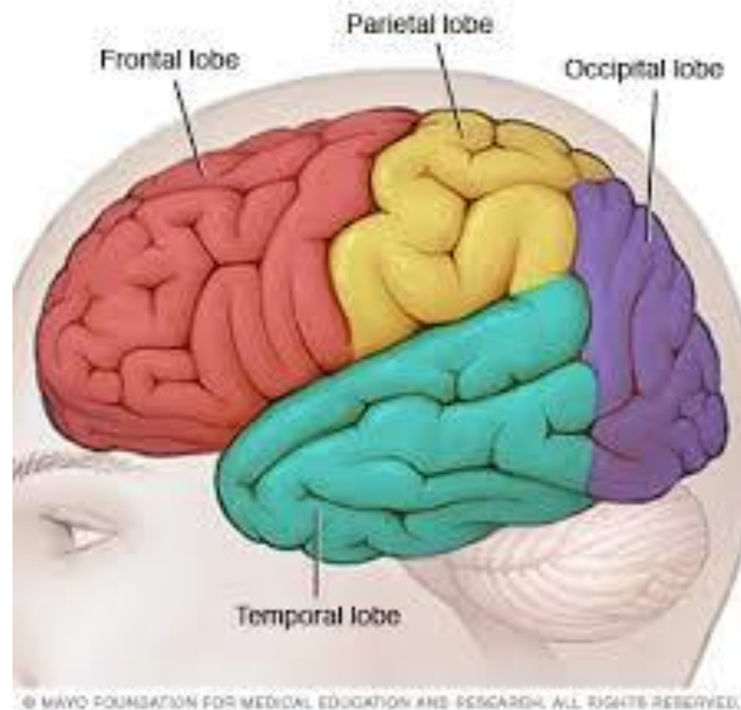
PAULA CASE*

- Lack of insight, reported by psychiatrists in particular, as a cause of lack of capacity occurred in a third of 57 British health and welfare COP judgments from 2007 to 2015

- 'lack of insight' as a metaphor for incapacity.

- "…experts' liberal deployment of the concept of 'insight' if not kept within proper limits has the potential to corrupt the assessment of capacity… and can threaten to undermine the statutory presumption of capacity…where P is refusing care or is otherwise 'uncooperative'".

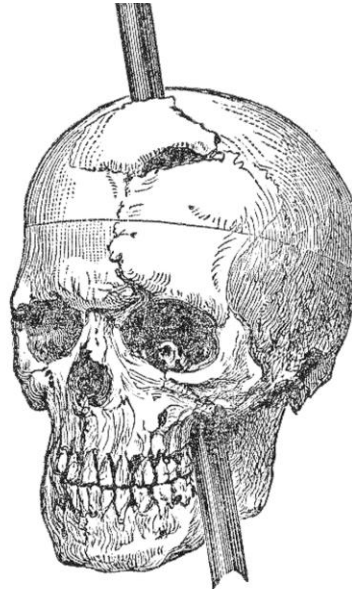
# Frontal Lobe of the Brain

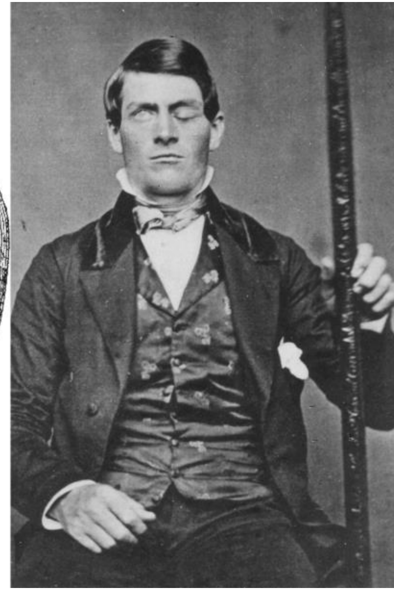



The control area for executive functions:

Decision-making, planning, judgement, directing complex goal-directed behaviours.

# Executive/Frontal lobe impairment





*"He is fitful, irreverent, indulging at times in the grossest profanity (which was not previously his custom), manifesting but little deference for his fellows, impatient of restraint or advice when it conflicts with his desires, at times pertinaciously obstinate, yet capricious and vacillating"*

# Frontal Lobe Paradox and Mental Capacity

- Patients can perform well in interview and test settings, despite marked impairments in everyday life - “good in theory, poor in practice”

- [With regard to] MCA assessments… a structured interview may help people with executive deficits to hide their problems … Capacity is measured in the abstract with this approach; the individual’s stated intention is assessed, rather than their actual functioning.

- Although a hallmark is a lack of insight into their need for support or supervision, patients also may present with intact insight because they can often say what they should have done when questioned about their errors. The key problem that they ‘*do not do what they said they intended to do*’

George, Gilbert 2018; UK ABI Forum submission 2019

# Proposed Solutions

- MCA assessors should check the veracity of an individual's self-report by ensuring that it is congruent with their performance in everyday life. Collateral information should be sought from clinicians who have conducted functional assessments and family members.

- … whilst these professionals often have considerable experience in conducting MCA interviews, they may lack specialist expertise in assessing people with neurological conditions

BUT

- Return to outcome approach to capacity
- Professionalising assessments

# Perils of Executive Dysfunction

- Many people ‘fail’ neuropsychological tests of executive function.
- Causes of executive dysfunction include: medications, insomnia, diabetes, chronic heart, lung, kidney and liver disease, adolescence – Everything essentially!
- *NCC v PB and TB*: one expert witness stated that the person “has compromised executive function stemming from her frontal lobe” and another that she had “frontal lobe damage” – no brain imaging to support.
- Circular argument: if you are make ‘bad’ decisions, you probably have frontal lobe or executive dysfunction, which suggests you lack capacity to make decisions.

# Could never happen.....?

*He's made an unwise decision*

*There must be something wrong with him*

*Damn! The CT brain and the MMSE are normal.*

*Hmm.....*

*I know! The neuropsychologist will have some test that will be abnormal.  Hello, can you help?*

*Of course – executive dysfunction! Is there some brief test I can use next time?*

# Some solutions?

- Take presumption of capacity seriously! Do as few ‘capacity assessments’ as possible. Support decision making.
- Set an attainable threshold for capacity
  - “Drilling Deep into the ADM Act 2015”
  - Not Drilling Deep into the relevant person
- Not a panacea but standardised assessments better than not
  - – Transparent, more reproducible
  - – Less looseness ‘insight’, ‘executive dysfunction’
- Need for scrutiny, scepticism, more rigour, less deference