The misuse of the Mental Capacity Act. ‘You have capacity to end your life and there is nothing we can do about it.’

Abstract

The principle of "assume capacity" is one of the central tenets of the Mental Capacity Act (2005). It aims to preserve and enshrine the rights of capacious adults to make decisions about their social and medical care. The honourable intention was to empower and liberate vulnerable adults whilst protecting them from coercive practices and medical paternalism. However, the principle of "assume capacity" is problematic when it comes to suicide and mental health. Specifically, regarding mental health service users, who present to emergency mental health services, expressing thoughts and plans of suicide. In these cases, the principle of "assume capacity” is often misappropriated, misunderstood, and misapplied. The statue is erroneously quoted to give a false veneer of legal authority to the refusal of care. The mainstream suicide rhetoric in the UK and beyond, is one of speak out and seek help. This paper unashamedly highlights the fate of those diagnosed with mental health conditions who do reach out for help and are given a damaging message of ’you have capacity to choose to end your life. It is crucial that the principle of "assume capacity" is applied with caution and is balanced with the need to provide appropriate support and care to individuals who may be at risk of suicide.

Introduction

The central argument of this paper is that the assumingly empowering and liberating Mental Capacity Act (MCA) (2005)specificity principle 1(2) is misused, misunderstood, and misapplied to people with mental health conditions seeking urgent mental health treatment and care for suicidal thoughts and plans. As a person who has sought such support, I will use my own, and others experiences to illustrate this argument, alongside a theoretical challenge to the MCA. Principle 1 (2) will be critically analysed in relation to mental health service users seeking emergency mental health care due to suicidal thoughts. In these cases, the principle of "assume capacity" is often misappropriated, misunderstood, and misapplied. The statue is erroneously quoted to give false legal authority to the refusal of care.

The Mental Capacity Act (2005)

The Mental Capacity Act (MCA) (Department of Health, 2005) provides a legal framework for making decisions on behalf of people aged sixteen and over, residing in England and Wales, who lack the capacity to make those decisions for themselves. The introduction of the Mental Capacity Act marked a turning point in the statutory rights of people who may lack capacity. The legal rights given to people aimed to be transformative and empowering in nature. The MCA (2005) defines a person who lacks capacity as someone who is unable to make a specific decision for themselves, at the time it needs to be made, due to a temporary, or permanent impairment or disturbance of the mind or brain.

Principle 1 (2) '*A person must be assumed to have capacity unless it is established that he lacks capacity*'

Principle 1 (2) is one of the central tenets of the Mental Capacity Act (2005). It aims to preserve and enshrine the rights of capacitous adults to make decisions about their social and medical care. This principle means that individuals should be assumed to have capacity to make decisions for themselves, unless it is established that they lack capacity. It was intended to be empowering and liberating for vulnerable adults, protecting patients from coercive practices and medical paternalism. However, the principle of “assume capacity” is problematic when it comes to suicide and mental health.

Capacity for suicide?

Mental health service users, often with a diagnosis, or assumed diagnosis, of emotionally unstable personality disorder, are told either explicitly or implicitly, that ***‘you have capacity to choose to end your life and there is nothing we can do about it.’*** Sadly, this is not my own exclusive experience. It is a dangerous and widespread practice extensively discussed within service user and survivor communities (Hibbins, 2020) (Hibbins, 2019) (Aves, 2022) (Langley & Price., 2022)However, there is little published research on this rhetoric, and it has only very recently made its way into academic journals (Beale, 2022) There appears to be some commonality in the lived experience accounts. These common features will be critically examined within this paper and demonstrated as illegal, immoral, and unacceptable clinical practices.

Common features in lived experience accounts

There is an assumption of capacity despite evidence of mental illness or distress.
No capacity assessment is completed to either justify or question this assumption of capacity.
The unconfirmed assumption of capacity is used as a justification to deny mental health care. Service users are given the message – either implicitly or explicitly **– 'you have capacity to end your life and we cannot do anything about it.'**

There is an assumption of capacity despite evidence of mental illness or distress.

The first argument illustrating misuse of the MCA (2005), is that the principle of 'assume capacity' is erroneously misunderstood. The presence of mental illness or distress not taken into consideration. One might expect that to a lay person, the mere presence of mental illness and expressions of suicidal thoughts, would be reason to doubt someone's capacity or 'sound mind.' Yet within mental health services the evidence shows us this is far from the case (Aves 2022). Mental health service users presenting to services in a mental health crisis exhibiting elevated

levels of distress are assumed to have capacity to end their lives (Langley & Price., 2022).

This initial fundamental error is obvious when reading the full statue. The actual wording of Principle 1 (2) is as follows **'***A person must be assumed to have capacity unless it is established that he lacks capacity'.* (MCA, 2005). This is a full uninterrupted, sentence of sixteen words with a clear exception. Or to use the exact wording of the Act **– *'unless it is established that he lacks capacity.'*** It is clear from reading the MCA (2005) that capacity is not to be blindly assumed in all situations.

Therefore, if there is good reason for concern, and legitimate doubt to question capacity, the presumption of capacity cannot be used to avoid the assessment of capacity. It is well established within psychiatry that mental illness can impact thought processes and decision making. Mental illness or distress and the expression of suicidal thoughts is a reason for concern. Therefore, to misuse the MCA and blindly assume capacity by taking the first part of a sentence and ignoring the impact of mental illness on decision making is both unlawful and immoral.

No capacity assessment is completed to either justify or question this assumption of capacity.

The second aspect found in lived experience accounts is that the presumption of capacity is used as a reason to deny capacity assessments (Aves, 2022). This is backed up by the post legislative scrutiny of the MCA (House of Lords Select Committee, 2014). In practice, this means that distressed and suicidal mental health

patients are branded with the assumption of capacity, and this is backed up neither clinically nor legally.

This paper has already established that the presumption of mental capacity in the presence of mental distress is questionable clinical practice. The MCA is then further misapplied to neither confirm nor dispute this erroneous assumption. Again, this is not only ethically and morally questionable, but unlawful. As highlighted in case law, Section 1 (2) has logical limits. (Swift, 2020) states that when there is reason to doubt capacity, capacity *must* be assessed. We have already illustrated that the presence of mental illness and distress is reason to doubt capacity. Therefore, to not assess capacity is unlawful.

The MCA (2005) includes a two-stage test for determining whether an individual has capacity to make a specific decision. The first stage of the test is to determine whether the individual has an impairment, or a disturbance in the functioning of the mind or brain. This includes mental health conditions. The second stage of the test is to assess whether the impairment or disturbance renders the individual unable to make the specific decision in question. This requires an assessment of whether the person can understand the information relevant to the decision, retain that information, use, or weigh up the information as part of the decision-making process, and the finally communicate that decision to others (MCA, 2005).

Regarding mental health service users with thoughts or plans of suicide, it is reasonable to question their ability to use and weight up information as part of the decision-making process. Capacity assessments are time and decision specific. The decision in question is whether to end one's life. The presence of mental distress, including hopelessness, despair, or psychotic symptoms, all interfere with a person's

ability to use and weight up information. Therefore, capacity must be thoroughly assessed to guide clinical decision making. If clinicians are documenting in patients notes that someone 'has capacity' this must be clearly backed up by evidence of a capacity assessment considering the decision in question (suicide).

The presumption of capacity is used to justify non-intervention.

This final weaponizing of the misuse of the MCA is a perverse justification for clinical neglect. Confirming my own and others lived experience accounts, the post legislative summary found evidence that the presumption of capacity was **deliberately** used to support non-intervention by health and social care providers (House of Lords, 2014). It was used to avoid taking responsibility for vulnerable people expressing suicidal feelings and distress. This was again highlighted as recently as January 2023 by The Joint Committee on the Draft Mental Health Bill (House of Commons & House of Lords, 2023). They were disturbed by evidence revealing the concept of "assume capacity" has been misused to deny treatment to potentially suicidal patients when they have voluntarily sought it.

The fact that often service users are *requesting* help when are branded as having capacity is worthy of analysis. The MCA is most used when people are refusing treatment. Capacity is assessed on their ability to refuse treatment or interventions. However, this paper discusses people who are voluntarily asking for help. Capacitous people are not excluded from physical health care. An individual asking for help for a physical health problem, would not be denied this based on capacity. Is mental health care only for people who lack capacity?

What has been benignly labelled an ‘unanticipated consequence’ of the empowering principle of presume capacity, is resulting in the death of service users ((Broadbridge, 2022)). It has been used to justify inaction. This is clearly a gross misuse of the statute and not how the MCA it was intended to operate in the real world.

So far, this paper has critically examined the MCA principle 1 (2) and has highlighted unlawful, immoral, and neglectful clinical practices done under the guise of the MCA. Unfortunately, the misuse of the MCA cannot be eradicated or simply explained by a misunderstanding of the law. Mental health professionals are at minimum degree educated professionals who are required to understand the law and statue with which they operate. Does the blame lie with the MCA, or is this the latest covering for systemic stigma and the dehumanising of mental health patients?

The ‘take responsibility’ mantra

Predating the misuse of the MCA outlined in this paper, was the ‘take responsibility’ mantra. In a similar dismissal of suicidal distress, service users were instructed to ‘take responsibility’ for their choices. Asking for help was ‘behavioural.’ It held the perverse belief that if an individual really wanted to die, they would not be asking for help. I am ashamed that this was the establish rhetoric and culture of mental health services in early 2000 when I completed my mental health nurse training. Although not fully subscribing to the notion and remaining compassionate, I was implicit in some of its non-evidence based clinical practices. I implore clinicians to critically examine their own prejudices, established clinical practices, and reawaken compassion and kindness.

Suicide is not always a capacitous choice, and it can be prevented. Mental illness impairs decision making and can transport you to places of unimaginable fear and distress. If a miniscule flicker of hope remains, if a scarce survival instinct hauls someone to seek emergency mental health care, do not extinguish that hope.

The human cost

When mental health service users are told that 'you have capacity to end your life' they are deemed undeserving and unworthy of care. The harmful impact of this adds to already overwhelming feelings of rejection. It is a prime example of mental health services causing more harm than good and instigating iatrogenic harm.

The emotional impact of hearing this rhetoric, and the immediate consequences of having urgent mental health care withheld, is profound. It not only shatters self-esteem and self-worth but confirms an existing belief that one is undeserving of care. It is experienced as traumatising, abusive, and disempowering (Aves, 2022).

Conclusion

This analysis explores the misuse of the MCA. It has demonstrated that principle 1 (2) of the MCA is misunderstood, misapplied, and erroneously used to justify withholding care to mental health service users actively seeking help for suicidal thoughts. When principle 1 (2) is examined legally, this is clearly an unlawful misuse of the statue. Ethically and morally, it illustrates systemic attitudes of stigma and the dehumanisation of people experiencing distressing suicidal thoughts. Sitting alongside unlawful clinical practice is a lingering perverse attitude of mental health

professionals that suicide is a choice and cannot be prevented. Did this stem from the introduction of the MCA, or has the MCA been used to add a legal veneer to this pre-existing belief? Whichever came first, the MCA must no longer be used to justify withholding care to vulnerable people.

This paper is dedicated to all individuals and their families who have been impacted or lost their lives through the misuse of the Mental Capacity Act.

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