



OLDHAM ADULTS SAFEGUARDING BOARD

Executive Functioning: Mental Capacity Act Guidance



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With thanks to Lancashire Safeguarding Adults Board

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1. Introduction

- 1.1 Executive function is an umbrella term used to describe a set of mental skills that are controlled by the frontal lobes of the brain. When executive function is impaired, it can inhibit appropriate decision-making and reduce an individual's problem-solving abilities. Planning and organisation, flexibility in thinking, multi-tasking, social behaviour, emotion control and motivation are all executive functions.
- 1.2 Professionals assessing capacity in this patient group are faced with a number of obstacles that make determination of capacity more challenging. This can have significant implications because failing to carry out a sufficiently thorough capacity assessment in these situations can expose a vulnerable individual to substantial risk.

This document is intended to provide guidance to Mental Capacity professional practice. Learning from Safeguarding Reviews identifies the repetitive finding connecting effective assessment of executive impairment to practitioner confidence and expertise. Detecting executive impairment and assessing the effect on mental capacity can be very challenging. Structured assessments of mental capacity may need to be supplemented by real world observation of the persons functioning and decision-making ability. A practitioner's scope of practice is the limit of their knowledge, skills, and experience and as health or social care professionals, they must ensure that they work within this. Whilst their scope of practice is likely to change over time as their knowledge, skills and experience develop, any area of mental capacity assessment that falls outside of this, must be escalated via their line of authority to ensure adequate support and expertise is provided to both the practitioner and the assessment.

- 1.3 The main aim of this guidance is to increase the practitioner's awareness and detection of these issues, so that more specialist advice and support can be sought if required. Please see the below information and links which may help you when undertaking a capacity assessment around executive decision making. Please pay particular attention to the relevant case law and what has now been determined by the courts as being salient information to this decision. As with all MCA situations, the MCA Code of Practice is key guidance.

2. Mental Capacity – Basic Principles

- 2.1 Those undertaking capacity assessments need to remember the importance of applying Principle 2 of the Act. Even if someone is assessed as lacking capacity to make a decision, consideration as to whether their capacity could improve with additional support to understand the decision to be made. Whilst it is acknowledged that some decisions cannot wait and a determination on capacity and a best interest decision needs to be concluded, there may be some situations where with time, additional information/education, the individual may regain capacity in that area.
- 2.2 The five statutory principles are:
 1. An individual must be assumed to have capacity unless it is established that they lack capacity.
 2. An individual 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.
 3. An individual is not to be treated as unable to make a decision merely because he makes an unwise decision.
 4. An act done, or decision made, under this Act for or on behalf of an individual who lacks capacity must be done, or made, in his best interests.
 5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the individual's rights and freedom of action.

3. Assessing Capacity (MCA Code of Practice Page 41)

3.1 Anyone assessing an individual's capacity to make a decision for themselves should use the two-stage test of capacity.

3.2 **Is the Individual able to make the decision** in question at the time it needs to be made? (**the functional test**).

3.3 **Does the individual have an impairment of the mind or brain (the diagnostic test)**, or is there some sort of disturbance affecting the way their mind or brain works? (It doesn't matter whether the impairment or disturbance is temporary or permanent.) It is worth remembering that the definition of impairment of the mind or brain is very broad. Certain disorders of the mind or brain are more widely recognised to be associated with executive dysfunction and include acquired brain injury, dementia, delirium, learning disability, attention deficit and hyperactivity disorder (ADHD) and autism. However, many other mental disorders can be associated with executive dysfunction including schizophrenia, depression, anxiety, and personality disorders. Acute intoxication with drugs or alcohol is also an impairment of the mind or brain.

Assessing Ability to Make a Decision

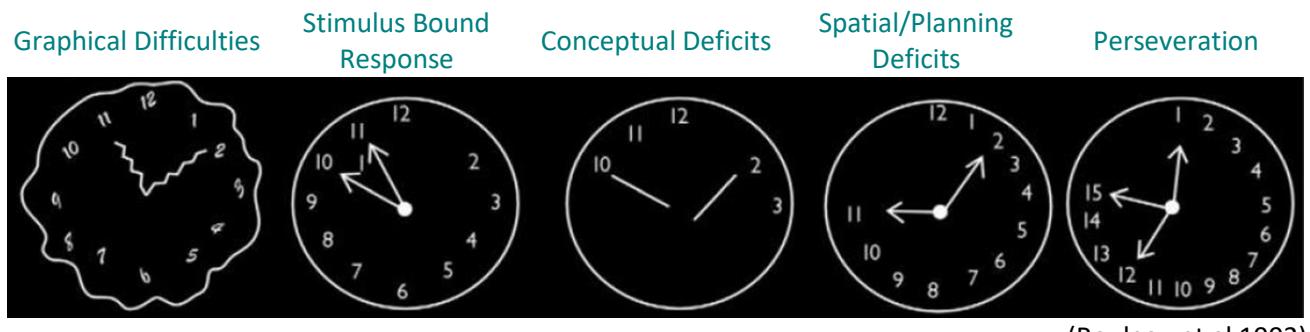
- Does the individual have a general understanding of what decision they need to make and why they need to make it? Does the individual have a general understanding of the likely consequences of making, or not making, this decision?
- Is the individual able to understand, retain, use, and weigh up the information relevant to this decision?
- Can the individual communicate their decision (by talking, using sign language or any other means)? Would the services of a professional (such as a speech and language therapist) be helpful?

4. Screening for Possible Executive Impairment

4.1 The clinical history will often provide clues suggestive of executive impairment. A pre-existing mental health diagnosis may raise the suspicion of executive impairment. The individual with executive impairment may show the following signs:

- Unable to translate intention into action
- 'Full of promises' and plausible
- Apathetic
- Inability to initiate, plan and sequence activities
- Struggling with new situations (better with familiar)
- Behaviour is aimless, impulsive, and fragmented
- Unable to monitor and evaluate their own actions
- Unable to think flexibly or abstractly
- Less able to adapt to change
- Black and white thinking style
- Lack of a filter in social situations.

4.2 If practitioners suspect an individual may have impaired executive function, there are also number of quick and easy screening tests that can be performed at the bedside (Ismail et all 2010). The clock drawing test (Rouleau et al 1992) is probably of the simplest to use and most effective. Common errors are shown below. Individuals with impaired executive function often demonstrate errors such as stimulus bound response (putting the long hand pointing towards 10 for '10 past 11', planning deficit (a tendency to bunch all of the numbers together) and perseveration (continuation beyond 12 or repeating the same numbers). Crucially, an individual with any significant executive impairment will struggle to draw a clock without errors.



(Rouleau et al 1992)

4.3 Other tests are available to determine frontal lobe dysfunction, please contact your local safeguarding leads who can link to neuropsychology as appropriate.

4.4 Individuals with executive impairment can often present very well in a formal assessment of cognition and capacity. They can often mask their deficits, and often unaware they are doing so. Despite this, there is often signs that they still struggle in day to day life. This is known as the 'frontal lobe paradox'.

4.5 An example of this difficulty: 'is where an individual with an acquired brain injury gives superficially coherent answers to questions, but it is clear from their actions that they are unable to carry into effect the intentions expressed in those answers'. In other words, they are good in theory but poor in practice.

4.6 Two of the main reasons for this are that individuals with executive impairment are often not aware of any cognitive deficit (problems with awareness of deficit) and are unable to think about or reflect on their own cognitive processes (problems with metacognition or 'thinking about thinking').

4.7 Problems with executive function might be suspected if an individual seems, in theory, to appreciate and understand their situation, but is then is struggling to elicit the relevant bits of information and use them in the right context. They may also struggle to act upon or execute a decision.

4.8 To further complicate the picture, many of the traits and behaviours observed in executive impairment vary in degree, (they exist on a continuum) and are also observed in the normal healthy population (they overlap with health population). This means it can be difficult to know if the behaviour or trait is pathological and therefore likely to be impairing capacity.

5. Impulsive Decision Making

5.1 **Impulsivity** is a good example of a behaviour that can affect decision making and is often observed in those with executive dysfunction. Yet it is also a widely recognised character trait or behaviour in the normal healthy population. Deciding when an impulsive decision is pathological and indicating a lack of capacity can therefore pose a challenge to the assessor. Crucially, a link (or causative nexus) needs to be established between the apparent impulsive decision and any underlying impairment of the mind or brain.

5.2 Signs that impulsivity is more likely to be related to an underlying mental disorder and therefore may result in impaired capacity might be:

- Evidence of a mental disorder commonly associated with executive impairment or impulsivity.
- Other signs of executive dysfunction.
- The impulsivity is a new change in behaviour.
- A more severe degree of impulsivity e.g. marked variability and inconsistency in the impulsive decision reached moment to moment, an obvious disassociation between the impulsive decision made and the impulsivity is present even in the context of more significant, complex, and high stakes decisions i.e. the individual cannot not adapt their behaviour in keeping with the gravity of the decision.

- Deficit in self-awareness and ‘metacognition’ - lack of self-awareness of their impulsivity, for example, an individual with capacity will be able to self-reflect on their impulsive tendencies and incorporate that into their decision making.
- Pervasiveness of impulsive behaviours - evidence of marked impulsivity in other aspects of daily life causing significant social and functional impairment.

6. Unwise Decision Making

6.1 Distinguishing between unwise decision making and decisions affected by executive impairment can also pose a challenge. Firstly, the assessor must not inadvertently use an outcome test for capacity i.e. deciding an individual lacks capacity based on the unwise or risky nature of the decision. However, particularly in executive impairment, it is often the risky or unwise decision or behaviour that trigger closer scrutiny of an individual’s capacity. What remains important is that the assessor uses the functional test, looking at the process of how the individual reached that decision.

6.2 Fundamentally, in unwise decision making, the individual is fully aware but consciously disregarding or giving less weight to certain facts relevant to the decision. In executive impairment, the individual cannot access and integrate the correct pieces of information and use them in a meaningful way to make the decision.

7. Defensible Recording of Assessments

7.1 Recording is an integral and important part of all Mental Capacity Assessment. It is central to demonstrating good, person-centred support and is a hallmark of defensible decision making. Defensible recording is vital because:

- It assists good care and support
- It is a legal requirement and part of staff’s professional duty
- It demonstrates reliable assessments were used and information was thoroughly evaluated
- It promotes continuity of care and communication with other agencies
- It demonstrates processes and procedures were followed
- It is a tool to help identify themes and challenges in a person’s life
- It is key to accountability – to people who use services, to managers, to inspections and audits
- It is evidence – for court, complaints and investigations

It will enhance practice and the support offered if good recording is a central part of process.

8. General Considerations: Re-Assess and Take a More Holistic Approach

8.1 Mental capacity law emphasises the need to balance paternalism (protecting an individual who lacks capacity from harm) against autonomy (allowing the individual to make their own decisions) wherever possible. In these particular cases it is good practice to regularly re-assess capacity to ensure that an individual has the opportunity to learn and grow despite the effects of their executive impairment. With the benefit of additional practicable steps (Principle 2) the individual may well be able to improve their decision-making capacity. Also, repeated assessment help to get a better sense of any repeated mismatch between the individual’s words and actions.

8.2 Although there is no case that is determinative of this point, Essex Chambers guidance states that:

- You can legitimately conclude that an individual lacks capacity to make a decision if they cannot understand or ‘use and weigh’ the fact that they cannot implement in practice what they say in assessment they will do.

BUT

- You can only reach such a finding where there is clearly documented evidence of **repeated mismatch**. This means, in consequence, that it is **very unlikely ever to be right to reach a conclusion that the individual lacked capacity for this reason on the basis of one assessment alone**. The application of this professional curiosity is fundamental in situations where executive functioning is questioned. (Allen, 2019)

8.3 George and Gilbert (2018) also recommend that:

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

8.4 This more longitudinal and holistic assessment of capacity is essential in detecting the more subtle effects of executive impairment on decision making. It is clear however that this approach does not sit neatly with the very distinct legal definition of a determination of capacity being decision and time specific, highlighting one of the difficulties with the current legal standards.

9. Is Mental Capacity Law Fit for Purpose?

9.1 It can be very difficult in these cases to identify whether the individual in fact lacks capacity as defined by the MCA 2005. This may partly be due to problems with the current legal standards. One criticism of the current legal standards for capacity is that they focus too narrowly on specific cognitive functions, to the exclusion of other factors that play a significant role in human decision making. For example, the current legal standard places value in reasoned and reflective decision making over spontaneity i.e. there is a strong **rationalist bias**. For more discussion in this area please see Charland (2006), Tan (2006), Craigie, (2011) and Whiting, (2020). The Mental Capacity (Amendment) Act 2019 received Royal Assent on 16th May 2019 and updates the code of practice to reflect case law, organisational and terminological changes to develop ways of working and best practice.

9.2 **Please remember that interpretation of case law can change over time. Workers should check for any significant changes to case law since this guidance has been written.**

10. Key Points

- Executive impairment can affect decision making capacity.
- It is often overlooked, resulting in potential exposure of a vulnerable person to risk.
- It can be very difficult to assess the effect of executive impairment on mental capacity for a number of reasons - repeated assessment of capacity, supported by collateral information and real-life functional assessment are recommended.
- If there are concerns that an individual's executive functioning may be affecting their decision-making capacity, it is probably worth seeking a specialist opinion from a psychiatrist or psychologist.

11. Helpful Links

Advocacy Focus

Plenty of easy read resources that may be helpful: <https://www.advocacyfocus.org.uk/justiceforlb>

Acquired Brain Injury and Mental Capacity

Acquired Brain Injury and Mental Capacity Act Interest Group. (2014). *Making the Abstract Real: Recommendations for action following the House of Lords Select Committee Post-Legislative Scrutiny Report into the Mental Capacity Act.*

<https://www.mentalcapacitylawandpolicy.org.uk/wp-content/uploads/2014/10/DoH-MCA-ABI-17-09-14.pdf>

Learning Disability, Autism, Mental Health, and Mental Capacity

Has section on executive function and capacity, with focus on patients with learning disability, autism and acquired brain injury. *Mental Health Act Restricted Patients and Conditional Discharge: Practice Considerations* <https://www.bild.org.uk/wp-content/uploads/2020/04/MM-practice-Guidance-FINAL.pdf>

Care Quality Commission

Failure to comply with MCA: <https://www.communitycare.co.uk/2010/06/17/professionals-fail-to-comply-with-mental-capacity-act/>

Commentary on a Court Of Protection Case involving Impaired Executive Function

<https://www.mentalcapacitylawandpolicy.org.uk/executive-dysfunction-under-the-judicial-spotlight/>

Essex Chambers

Case law review and commentary. Excellent for easy read summaries. Has a key word search which is useful.
<https://www.39essex.com>

Frontal Lobe Paradox Explained

Further information on the 'frontal lobe paradox' and relevance to mental capacity:

<https://www.bps.org.uk/blogs/guest/parliament-and-%E2%80%98frontal-lobe-paradox%E2%80%99>

<https://www.nrtimes.co.uk/frontal-lobe-paradox-how-can-we-best-help-service-users/>

Oldham Safeguarding Adults Board

Many resources available on the OSAB Website:

<https://www.osab.org.uk/professionals/policies/>

MCA Code of Practice

<https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice>

NICE Guidance

The 2018 National Institute of Clinical Excellence (NICE) guidelines on assessing capacity make specific reference to executive difficulties and recommend both real life observations and consulting other professionals involved in the individual's care. <https://www.nice.org.uk/guidance/NG108>

Office of the Public Guardian

<https://www.gov.uk/government/publications/search-public-guardian-registers>

<https://www.lastingpowerofattorney.service.gov.uk/home>

Screening for Executive Impairment

Open access article on tools used to screen for executive impairment.

Ismail, Z., Rajji, T.K. and Shulman, K.I., 2010. *Brief cognitive screening instruments: an update*. International Journal of Geriatric Psychiatry: A journal of the psychiatry of late life and allied sciences, 25(2), pp.111-120. <https://onlinelibrary.wiley.com/doi/epdf/10.1002/gps.2306>

'Where the Frontal Lobes Meet the Mental Capacity Act' by Dr Tracy Ryan

Excellent presentation on the role of the frontal lobes in decision making capacity:

<https://projects.swan.ac.uk/sasnos/wp-content/uploads/2020/01/Dr-Tracey-Ryan-Morgan-Decisions-Decisions-Decisions-%E2%80%93-Where-the-Frontal-Lobes-Meet-the-Mental-Capacity-Act.pdf>

Alcohol Change UK

'Alcohol related Brain Damage – Quick Guide for Professionals'

12. References

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<https://www.39essex.com/mental-capacity-guidance-note-brief-guide-carrying-capacity-assessments/>

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Charland, L.C., 2006. *Anorexia and the MacCAT-T test for mental competence: validity, value, and emotion*. *Philosophy, Psychiatry, & Psychology*, 13(4), pp.283-287.

Craigie, J., 2011. *Competence, practical rationality and what a patient values*. *Bioethics*, 25(6), pp.326-333.

George, M.S. and Gilbert, S., 2018. *Mental Capacity Act (2005) assessments: why everyone needs to know about the frontal lobe paradox*. *The Neuropsychologist*, 5(1), pp.59-66.

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Rouleau, I., Salmon, D.P., Butters, N., Kennedy, C. and McGuire, K., 1992. *Quantitative and qualitative analyses of clock drawings in Alzheimer's and Huntington's disease*. *Brain and cognition*, 18(1), pp.70-87.

Tan, J.O., Hope, T., Stewart, A. and Fitzpatrick, R., 2006. *Competence to make treatment decisions in anorexia nervosa: thinking processes and values*. *Philosophy, psychiatry, & psychology: PPP*, 13(4), p.267.

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Appendix 1 – Case Study

P was 23 when she died. She was brought up by her adoptive parents from being 12 weeks old until the age of fourteen. At this point P came under the care of Children's Services where she experienced four different residential placements.

P was an extremely bright young lady but the social side of school, and later on her relationships, often caused her some difficulties. In the early days of CAMHS involvement she became overly attached to a teaching assistant in school and these difficulties were the beginnings of her starting to move through professional services.

By the age of 11, P had a medical diagnosis of Asperger's Syndrome, Attachment Disorder, Oppositional Defiant Disorder, Emerging Borderline Personality Disorder and Anorexia Nervosa. P attempted to take her own life at the age of fourteen and as a child she had a history of self-harm and issues associated with trust and control.

Professionals felt that P never really came to terms with the fact that she was adopted or that her birth family did not want her.

As an adult, P was a victim of domestic violence and had a history of using alcohol to manage symptoms related to her mental health and Asperger's Syndrome. P came to the attention of services over the last three years of her life due to the high volume of calls to North West Ambulance Service NHS Trust (NWAS), Greater Manchester Police (GMP) and attendance at A&E. P disputed her diagnosis of Asperger's, mental health issues and alcohol dependency and as a result declined services that offered support in these areas. P talked about wanting to take her own life on numerous occasions.

P was described as very intelligent and articulate when calm but who had very significant anger and behavioural problems

P died as a result of alcohol dependency and self-neglect due to long standing mental health issues that had not been addressed. Formal Mental Capacity Act Assessments were undertaken which routinely assessed P as having capacity to understand the risk her behaviours posed to her health. However, her behaviours over a period of time showed that she did not have the capacity to execute decisions. In their recent publication "How to use legal powers to safeguard highly vulnerable dependent drinkers in England and Wales", Professor Michael Preston-Shoot and Mike Ward suggest that,

"Chronic, highly vulnerable, dependent drinkers may not have a diagnosed mental illness such as schizophrenia, but they are often functionally mentally disordered at a level where freedom of choice over their behaviours is largely absent."

In addition, P's refusal to accept a diagnosis of autism or a mental health condition meant that she did not access services that could have helped her situation and, significantly, her long standing mental health issues were never assessed as an adult. As a result, it is not clear how her capacity to execute decisions was also influenced by her childhood trauma, autism, or mental health issues.

In January 2020 P was admitted to hospital and placed on a Section 2 following a Mental Health Act Assessment. The assessment found she had a mental disorder that was impacting on her ability to manage her physical health needs and she posed a risk to herself and others. Adult Social Care shared information about P's long-standing behaviours with Mental Health Services following a request for information to review of the section 2 arrangements.

Despite this the Section 2 was removed, resulting in a missed opportunity to explore her mental health condition/s including her Pathological Demand Disorder. In addition, a decision was made by the Hospital to allow P to leave hospital the day before her death. A capacity assessment by a senior doctor that was

decision specific and did not consider her wider history. There were no records of any legal consideration made to detain her in light of previous levels of intoxication.