



# 5 Myths about Mental Capacity

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Disclaimer: personal views only



# Myth 1: Mental capacity is an invalid concept

- UN Committee on the Rights of Persons with Disabilities: mental capacity is not “as commonly presented, an objective, scientific and naturally occurring phenomenon. Mental capacity is contingent on social and political contexts, as are the disciplines, professions and practices which play a dominant role in assessing mental capacity.”
- Functional model is flawed because “it 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 him or her a core human right – the right to equal recognition before the law.”
- => functional model of capacity = discrimination contrary to Article 12 CRPD
- [Mental capacity—why look for a paradigm shift? | Medical Law Review | Oxford Academic](#)

# Myth 2: Mental capacity is well-understood

[Margaret Flynn](#), Chair of the National Mental Capacity Forum:

*7. Despite the congruence of interests and agreement on the necessity of the MCA, the case studies in the 2022-23 annual report and the, as yet unpublished, annual report of 2023-24, confirm the enduring "lack of awareness and a lack of understanding" reported by the House of Lords Select Committee in 2014. (I was disappointed to read Professor Chris Whitty's oral evidence to the Committee that "the more serious the decision, the greater the level of capacity that someone needs to have," not least because "greater capacity" does not sit with what the MCA requires.)*[full disclosure, I am on the NMCF leadership group, so have been involved in assisting Margaret Flynn in her work on both of the annual reports].

National Institute of Health Research funded in 2022 a number of (ongoing) research projects under the umbrella: [Implementing the Mental Capacity Act in practice \(Mental Capacity Assessments\) | NIHR SSCR](#), the rationale being that:

*The Mental Capacity Act 2005 (MCA) is designed to empower and protect people who may lack the mental capacity to make their own decisions about their support and treatment, ranging from everyday issues to more serious, life-changing decisions. Evidence has highlighted several aspects of the way assessments are being carried out which are not compliant with the MCA. There is also a lack of evidence relating to the validity and acceptability of available assessment tools, the effectiveness of health and social care staff training, and how the MCA is embedded (or not) throughout organisations. Research which evaluates the effectiveness of training and assessment tools and resources, the embeddedness of the MCA in practice, and the impact of the Act on individuals using services across health and social care, is needed to support policy and service decision-makers such as commissioners, health and social care professionals, and people who use services as well as informal carers.*

The Care Quality Commission in its most recent *State of Care* report in October 2024 ([The state of health care and adult social care in England 2023/24 - Care Quality Commission](#)) also noted (at page 129) that:

*The Mental Capacity Act 2005 (MCA) directly affects the lives of millions of people. Everyone providing care to people over the age of 16 must be familiar with this vital piece of legislation, which introduced rights and protections for people who may lack mental capacity. A decade after the House of Lords report, we continue to find a lack of understanding of the MCA among providers. Any action taken as part of the DoLS process must be in line with the principles of the Act. While providers often demonstrate an awareness of the MCA and its principles, many managers and staff still lack confidence in applying them in their work. This is reflected in care records, mental capacity assessments and best interests decisions. We found that some care records did not show how best interests decisions were made and how the appropriate people were involved.*

## Myth 3: Mental capacity is always difficult

- ? 85% of capacity determinations by those who actually understand the law are relatively straightforward, with difficulty arising because of (1) not having enough time; or (2) not listening to the person
- Wellcome Trust funded research to try to assist with the 15%: [www.capacityguide.org.uk](http://www.capacityguide.org.uk)
- [Difficult Capacity Cases—The Experience of Liaison Psychiatrists. An Interview Study Across Three Jurisdictions](#): four key sources of difficulty in capacity assessment, spanning both clinical and ethical domains:
  - Difficulty determining whether the decision is the patient's own or driven by illness,
  - Difficulty in applying ethical principles,
  - Difficulty in avoiding personal bias, and
  - Procedural difficulties (Lack of Engagement, Lack of Information to Verify Facts, Interpersonal Conflicts Between Patient and Team, When “Please Assess Capacity” Belies Therapeutic Concerns

## Myth 4: A capacitous request holds the same weight as a capacitous refusal

68. The common law authorities so far considered therefore establish (i) that a patient with capacity can choose between various treatment options, which choices have to be respected by the clinicians even if the treatment chosen is not the one that was recommended by the treating team and (ii) a patient with capacity can refuse medical treatment. That then leaves the question as to whether, as advocated by Ms Weeraratne, there is a common law right of autonomy which allows a patient to demand, and obliges a clinician to provide, medical treatment that is not offered to that patient by their doctors.

69. In my judgement, the answer is an unequivocal 'No'.

*JJ v Spectrum Community Health CIC* [2023] EWCA Civ 885

- And nb: the BMA position: [Physician assisted dying](#).

The BMA's view is that assisted dying is not a 'treatment option' in the conventional sense and so the Supreme Court judgments of [Montgomery](#) (concerning the scope of information that must be provided when seeking consent to treatment) and [McCulloch](#) (which covers doctors' duties to raise treatment options with patients) are not relevant to assisted dying.

## Myth 5: Mental capacity is enough

- "[T]he inherent jurisdiction can be exercised in relation to a vulnerable adult who, even if not incapacitated by mental disorder or mental illness, is, or is reasonably believed to be, either (i) under constraint or (ii) subject to coercion or undue influence or (iii) for some other reason deprived of the capacity to make the relevant decision, or disabled from making a free choice, or incapacitated or disabled from giving or expressing a real and genuine consent." Munby J in *Re SA (Vulnerable Adult with capacity: Marriage)* [2005] EWHC 2942 (Fam)
- [Mental Capacity Guidance Note - Inherent Jurisdiction | 39 Essex Chambers](#)
- See also [Interpersonal influence and decision-making capacity – in conversation with Kevin Ariyo – Mental Capacity Law and Policy](#)

# Resources

- Complex Life and Death Decisions group written evidence to Terminally Ill Adults (End of Life) Bill Committee:
  - [Terminally Ill Adults \(End of Life\) Bill \(29th January 2025\)](#) (observations about capacity in the context of assisted dying)
  - [Terminally Ill Adults \(End of Life\) Bill \(11th February 2025\)](#) (distinction between capacity to refuse medical treatment and capacity to request assistance in dying)
- [39 Essex Chambers Mental Capacity Law Resources](#)
- [Mental Health & Justice](#)
- [Mental Capacity Law and Policy](#)