Derbyshire Safeguarding Adults Board

derby safeguarding adults board

Mental Capacity Act (2005) Subgroup

Mental Capacity and Best Interests Decisions – Everyone's business

In health and social care settings the consideration of a person's decision-making ability is central to the delivery of care and treatment. It is everyone's business. Decisions can relate to the day-to-day delivery of care to complex decisions relating to medical treatment or long-term care decisions.

Colleagues need to follow the principles of the Mental Capacity Act (2005) and demonstrate a professional curiosity in relation to an individual's decision-making ability.

To support colleagues in this work, guidance has been developed to increase confidence when working with and applying the Mental Capacity Act in practice.

Take a look at the guidance, share with teams and consider discussing this in relation to your own practice, sharing your reflections and learning with colleagues.

You can access the guidance via the following links.

Guidance to Assessing Mental Capacity and Making Best Interest Decisions (derbysab.org.uk)

Guidance to assessing mental capacity and making best interests decisions (derbyshiresab.org.uk)

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39 Essex Chambers: Mental Capacity Act Resource Centre

39 Essex Chambers is a really helpful source of information for practitioners who are interested in updates in case law and practice related to the Mental Capacity Act. They regularly publish reports and also have an area on their website with useful resources, all of which can be downloaded from their website at https://www.39essex.com/information-hub/mental-capacity-resource-centre.

Capacity and the impact of Trauma on decision making

Trauma is when we experience very stressful, frightening, or distressing events that are difficult to cope with or out of our control. It could be one incident, or an ongoing event that happens over a long period of time. (Mind, 2024).

Most of us will experience an event in our lives that could be considered traumatic. But we won't all be affected the same way. Trauma can happen at any age. And it can affect us at any time, including a long time after the event has happened. (Mind, 2024).

Trauma can come from adverse childhood (bmj, 2020) or life experiences, or can be sourced from your environment/community. The effects can result in 'Post-Traumatic Stress Disorder (PTSD) and often manifest in either physical reactions, emotional reactions, or both. Physical can manifest as freeze, flop, fight, flight, fawn, and result in panic attacks or hyperarousal. Emotional can include flashbacks, dissociation, sleep problems, self-esteem issues, grief, shame or in extreme events – suicide, self-harm (Van der Kolk, pp52-53).

For example, the amygdala (walnut sized part of the pre-historic brain) can rewire to interpret certain situations as harbingers of life-threatening danger. They can send signals to our 'survival' brain to fight, freeze etc. If these reactions all happen simultaneously, you may see agitation or even 'shut down'. One of the ways the memory of helplessness is stored as muscle tension or feelings of disintegration in the affected body areas, head, back and limbs in accident victims, vagina and rectum in sexual abuse victims. The lives of many trauma survivors come to revolve around bracing against neutralising unwanted sensory experience. This often results in people becoming experts in such 'self-numbing'. They may become serially obese or addicted to exercise or work. Drug use/cutting as numbing, OR as sensation seeking or high-risk activities. Any of these methods can give a false and paradoxical feeling of control (Van der Kolk, pp265-266).

"The nucleus of the neurosis is a physio neurosis" (Kardiner 1941, cited in Van der Kolk p11) In other words, post-traumatic stress isn't "all in one's head" as some people supposed but has a physiological basis. Kardiner understood even that the symptoms have their origin in the entire body's response to the original trauma.

As such trauma has a physical and emotional impact on our capacity to make decisions. Amnesia – people can have no memory of the traumatic events. Dissociation – (Pierre Janet, cited in Van der Kolk, p180). Splitting off and isolation of the memory imprints some can dissociate (stare at walls, lack of awareness of surroundings). Long term physical impact can include Fibromyalgia, chronic fatigue, autoimmune diseases (Cambridge, 2015).

There can be a heavy cost of keeping their traumatic experiences at bay. Often patients become: “Attached to an insurmountable obstacle”. Unable to integrate traumatic memories they can lose their capacity to assimilate new experiences as well as if their personality has stopped at a certain point and cannot enlarge anymore by assimilating new elements. (Post traumatic decline (JL Titchener cited in Van der Kolk).

It can include Re-enactment – acting out the event including physically. Can be lonely, humiliating and alienating experiences.

How to help people?

We need to prevent Re-traumatisation. It is vital not to re-traumatise people when helping making decisions (particularly when using Principle 2 of S.1 Mental Capacity Act).
Attending

This means being present with and focusing on others – ‘listening with fascination’ (Kline 2002). Listening is probably the most important skill and compassionate practitioners take time to listen to the challenges, obstacles, frustrations and harms people experience as well as listening to accounts of their successes and joys (West 2021).

Understanding

This involves taking time to properly explore and understand the situations people are struggling with. It implies valuing and exploring conflicting perspectives rather than simply imposing their own understanding (Gallo 2017).

Empathising

This involves mirroring and feeling people’ distress, frustration, joy, etc, without being overwhelmed by the emotion and becoming unable to help (West and Chowla 2017).

Helping

This involves taking thoughtful and intelligent action to support people. Collaboratively identifying and removing obstacles that get in the way of people doing achieving goals.
If people know their triggers, then we need to work with them – some may understand what works. E.G “Grounding techniques” – name 10 things around in this room so it brings them back in to the present rather than the past (if they can tolerate it). Be with them, physically ground. People can be their own ‘expert’ so use that to collaboratively work together.

Don’t forget using Principle Two of the Mental Capacity Act Section 1. We need to be aware of Trauma informed practice in Safeguarding:

Safety; Choice; Collaboration; Trustworthiness; Empowerment and Cultural consideration:

- **Give them time.** Let them talk at their own pace – it's important not to pressure or rush them.
- **Focus on listening**. Try to respect what they are choosing to share, rather than asking lots of questions.
- **Accept their feelings.** For example, allow them to be upset about what has happened.
- **Don't blame them or criticise their reactions**. You might wonder why they didn't do something differently, but they survived however they could at the time.

- **Use the same words they use.** People vary in how they prefer to describe their experiences. For example, it's their choice whether to talk about being a 'victim' or 'survivor' of trauma.
- **Don't dismiss their experiences.** For example, don't tell them not to worry about things or that it could be worse – this isn't usually helpful to hear. Try to remember that people can't choose what they find traumatic or how they're affected.
- **Only give advice if you're asked to.** They might prefer to simply hear that you believe them and are there for them.

References/further reading:

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