
Mental Capacity Law Guidance Note

A brief guide to carrying out capacity assessments

A: Introduction

1. This purpose of this document is to provide for social workers and those working in front-line clinical settings a brief overview of the law and principles relating to the assessment of capacity. Its focus is on (a) how to apply the MCA 2005 principles when assessing capacity; and (b) how to record your assessment, primarily in the context of health and welfare decisions.¹
2. This document cannot take the place of legal advice. In any case of doubt as to the principles or procedures to apply, it is always necessary to consult your legal department. In particular, if it appears that the individual in question is subject to undue influence or coercion, it is always vital to consult your legal department as soon as possible to consider whether it is necessary to make an application to the High Court under its inherent jurisdiction.

B: Key principles

3. The core principles of the MCA 2005 are set out in s.1(1). They are:
 - s.1(2): a person (P²) must be assumed to have capacity unless it is established that he lacks capacity;
 - s.1(3): P 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.

¹ The Department of Health has commissioned guidance that will be available later in 2014 on the carrying out of capacity assessments in relation to decisions regarding property and affairs.

² Strictly, of course, P is not 'P' unless they are the subject of proceedings before the Court of Protection who is alleged to lack capacity to take one or more decisions (Court of Protection Rules 2007, r7), but it is a convenient shorthand.

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- s.1(4): P is not to be treated as unable to make a decision merely because he makes an unwise decision.
 - s.1(5): an act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
 - s.1(6): 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 person's rights and freedom of action.
4. The presumption that P has capacity is fundamental to the Act. It is important to remember that P has to 'prove' nothing. The burden of proving a lack of capacity to take a specific decision (or decisions) always lies upon the person who considers that it may be necessary to take a decision on their behalf (or will invite a court to take such a decision). The standard of proof which must be achieved is on the balance of probabilities (s.2(4)). Accordingly, it will always be for the decision-maker to prove that it is more likely than not that P lacks capacity.
5. Common phrases which suggest that this approach is not being adopted include:
- “[P] is unable to show that she had considered the option of [xxxx].”
 - “One needs to be certain of her capacity.”
 - “[P] is unable to fully understand, retain and weigh information.”³
6. It is also important that it is the decision-maker who needs to be satisfied that P lacks capacity. In a court setting, the decision-maker is the judge; outside the court setting, it is the person who is proposing to take the step in question on the basis that it is said to be in P's best interests.
7. We consider it inappropriate for those in clinical settings to expect those with psychiatric or psychological expertise to be responsible for the decision whether or not P has the capacity to (say) consent to an operation or to leave an A&E department. Unless the person with psychiatric or psychological expertise is actually making the decision as to whether to carry out the act in question – whether that be to carry out the operation or to allow P to leave (both of which are unlikely) – the true position in law is that they are simply providing expert assistance to the decision-maker to allow the latter to decide: (1) whether they are satisfied that P lacks capacity to take the decision in question; and (2) whether they are therefore able to rely upon the defence provided in s.5 MCA 2005 in relation to acts carried out in connection with the care and treatment of P.

³ All of these are taken from the judgment of Peter Jackson J in [Heart of England NHS Foundation Trust v JB](#) [2014] EWHC 342 (COP). Hyperlinks in this Guidance Note are to the case comments in the database maintained by the editors of the Thirty Nine Essex Street Mental Capacity Law [Newsletter](#). For further useful resources, see Section F below.

8. Whilst, as noted above, the judge before taking any final decisions upon the basis of P's best interests must be satisfied that they lack capacity, it is important to remember that the Court of Protection can make interim decisions and declarations about P's best interests where it has evidence before it "*to justify a reasonable belief that [the individual] may lack capacity in the relevant regard.*"⁴ This means that it is possible to make an application where those concerned with P's circumstances have been unable (perhaps because they have been prevented by a third party) to complete a COP3 form to the level of detail usually required. In such circumstances, it will always be necessary to make clear in a supporting witness statement why the person or body bringing the application has reasonable grounds to believe that P may lack the relevant capacity. One of the first steps that the Court will then take is to bring about a proper capacity assessment; that capacity assessment will then determine whether or not it has jurisdiction to take further steps in relation to P.

C: Defining a lack of capacity

9. A person who lacks capacity is defined under s.2(1) MCA 2005 thus:

'a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or the brain.'

10. Section 2(1) is the "*core determinative provision,*"⁵ supported by the remainder of s.2 and s.3, which flesh out what are traditionally called the two limbs of the capacity 'test', i.e. asking:

- whether P is 'unable to make a decision for himself' (functional); and
- whether that inability is because of 'an impairment of, or a disturbance of the functioning of, the mind or the brain' (diagnostic).

11. It is important to remember that none of the detailed provisions in the rest of ss.2 or 3 "*establish a series of additional, free-standing tests of capacity. Section 2(1) is the single test, albeit that it falls to be interpreted by applying the more detailed description given around it in ss 2 and 3.*"⁶

12. The single test consists of three elements:

(1) Is there an impairment or disturbance?⁷ If so:

(2) Is the person unable to make a decision? If so:

⁴ *Re F* [2010] 2 FLR 28.

⁵ *PC and NC v City of York Council* [2013] EWCA Civ 478 at paragraph 56.

⁶ *PC* at paragraph 56.

⁷ This will be particularly important if P's inability may be related to the presence of third parties: e.g. *LB Redbridge v G, C and F* [2014] EWHC 485 (COP).

(3) Is this inability because of the identified impairment or disturbance?

13. Depending upon the circumstances, it may be that more focus needs to be placed upon either diagnostic or the functional test – for instance – if P is in a psychiatric ward with a clear diagnosis of a mental disorder, then it may be that more attention is required to considering whether that disorder means that they are unable to take the specific decision in question. In all cases, though, all three elements of the single test must be satisfied.

14. We now look at these elements in turn.

(1): The Diagnostic Test

15. In many cases, capacity assessors will be relying upon a clinician to provide a diagnosis, and we do not therefore address this aspect of the test in great detail here. It is, though, important to make the following points.

16. First, the impairment or disturbance in the functioning of the mind or brain can be temporary or permanent (s.2(2)): if temporary, be careful to explain why it is that the decision cannot wait until the circumstances have changed before the decision is taken.

17. Second, it is important to remember that it is not necessary for the impairment or disturbance to fit into one of the diagnoses in the ICD-10 or DSM-V.⁸ It can include medical conditions causing confusion, drowsiness, concussion, and the symptoms of drug or alcohol abuse.

(2): The Functional Test

18. The elements of the functional test are found in s.3(1) MCA 2005, which states that P is unable to make a decision for himself if he is unable:

- to understand the information relevant to the decision; or
- to retain that information; or
- to use or weigh that information as part of the process of making the decision; or
- to communicate his decision (whether by talking, using sign language or any other means).

19. Before looking at each of these elements in turn, we should emphasise a number of cardinal principles that apply to all of them.

⁸ The revised COP3 form recognises this in section 7, where it requires the identification of the material impairment of or disturbance in the functioning of the mind or brain, and the identification of the specific diagnosis (or diagnoses) “[w]here this impairment or disturbance arises out of a specific diagnosis.”

20. First, capacity is decision-specific. The statement ‘P lacks capacity’ is, in law, meaningless. You must ask yourself “what is the actual decision in hand”⁹? If you do not define this question with specific precision before you start undertaking the assessment, the exercise will be pointless. By way of example:
- In *PC* itself, the decision was that of a learning disabled woman to resume living with her seriously risky husband upon his release from prison, which required consideration of the specific circumstances of that woman and that man;
 - In [Heart of England NHS Foundation Trust v JB](#) [2014] EWHC 342 (COP) the decision was whether to consent to surgical treatment for a potentially gangrenous leg: it was not whether to consent to one of the possible operations that could be carried out to provide that treatment.
21. Second, and linked to the first, as obvious as it may sound, it is also vitally important to ensure that, having framed the question with sufficient precision to yourself, you actually then ask P the question (in whatever manner is appropriate) during the assessment (and record the answer). If, unusually, it is not appropriate to ask the precise question, the reasons why it was not asked should be spelled out carefully.
22. Third, before you can determine whether P can satisfy the elements of the functional test, you must identify what the information relevant to the particular decision is. You should also record this information and explain which aspect(s) of it P is unable to understand, or retain, or use and weigh.
23. Fourth, to comply with s.1(3) MCA 2005, you must take all reasonable steps to help P before concluding that they are nevertheless unable to make a decision. This will include asking yourself – and being in a position to record – the answers to questions such as:
- What is the method of communication with which P is most familiar (is it, for instance, a pointing board, Makaton or visual aids)?
 - What is the best time of day to discuss the decision in question with P?
 - What is the best location to discuss the decision in question with P?
 - If you do not know P, would it assist to have another person present who does (and, if they do, what role should they play)?
 - What help does P require to learn about and understand the information relevant to the decision? For example, does P need to be taken to see different residential options?
 - And, perhaps above all, is there something that you can do which might mean that P would be able to make the decision? Depending upon the circumstances, this could range from simply waiting to undergo work with P to assist them: see for a good example, [Re DE](#) [2013] EWHC 2562 (Fam), in which (whilst Court of Protection proceedings were ongoing), an intensive programme of education was

⁹ See *PC* at paragraph 40.

provided to a learning disabled man, in consequence of which he gained the capacity to consent to sexual relations.

Is P unable to understand the relevant information?

24. It is not necessary that P understands every element of what is being explained to him: . What is important is that P can understand the ‘salient factors’¹⁰: the information relevant to the decision. This means that the onus is on you not just to identify the specific decision (as discussed above) but also what the information is that is relevant to that decision, and what the options are that P is to chose between. By way of an example from the medical sphere, in deciding whether a person has capacity to consent to a medical procedure, what the person needs to understand is:

“25... the nature, purpose and effects of the proposed treatment, the last of these entailing an understanding of the benefits and risks of deciding to have or not to have one or other of the various kinds of [operation under consideration], or of not making a decision at all.

26. What is required here is a broad, general understanding of the kind that is expected from the population at large. [P] is not required to understand every last piece of information about her situation and her options: even her doctors would not make that claim. It must also be remembered that common strategies for dealing with unpalatable dilemmas – for example indecision, avoidance or vacillation – are not to be confused with incapacity. We should not ask more of people whose capacity is questioned than of those whose capacity is undoubted.”

25. The level of understanding required must not be set too high.¹¹

26. Further, one must not start with a ‘blank canvas’:¹²

“The person under evaluation must be presented with detailed options so that their capacity to weigh up those options can be fairly assessed...before a person can be treated as lacking capacity to make a decision, it must be shown that all practicable steps have been taken to help her to do so. As the Code of Practice makes clear, each person whose capacity is under scrutiny must be given ‘relevant information’ including ‘what the likely consequences of a decision would be (the possible effects of deciding one way or another)’.”

27. When you are making an assessment of capacity it is vital that you ask yourself the questions set out at paragraph 18. Consider the responses, and record them in the assessment form or the COP3. Be in a position to explain to the court how questions have been put to P, where they have been put, and what efforts have been made to ensure that P understands the information before him or her.

¹⁰ [LBJ v RYJ](#) [2010] EWHC 2664 (Fam).

¹¹ [PH and A Local Authority v Z Limited & R](#) [2011] EWHC 1704 (Fam).

¹² [CC v KK & STCC](#) [2012] EWHC 2136 (COP).

Is P unable to retain the relevant information?

28. We repeat the need to be precise about the information in question.
29. P needs to be able to retain enough information for a sufficient amount of time in order to make a decision. The Act specifies at s.3(3), however, that ‘the fact that a person is able to retain the information relevant to a decision for a short period only does not prevent him from being regarded as able to make the decision.’
30. This is an important consideration, particularly when dealing with the elderly or those with deteriorating memories. Capacity is the assessment of the ability to make a decision ‘at the material time’: at the time of assessment. If information can be retained long enough for P to be able to make the relevant decision at the material time, that is sufficient, even if P cannot then retain that information for any longer period.

Is P unable to use or weigh the relevant information?

31. Again, it is necessary to be clear as to what the information is and how it is said to be relevant to the decision. This aspect of the test has been described as *“the capacity actually to engage in the decision-making process itself and to be able to see the various parts of the argument and to relate the one to another.”*¹³
32. The ability to understand also extends to understanding the reasonably foreseeable consequences of reaching a decision or failing to do so (s.3(4)).
33. It is particularly important here to be aware of the dangers of equating an irrational decision with the inability to make one – P may not agree with the advice of professionals, but that does not mean that P lacks capacity to make a decision:

*“there is a space between an unwise decision and one which an individual does not have the mental capacity to take and ... it is important to respect that space, and to ensure that it is preserved, for it is within that space that an individual’s autonomy operates.”*¹⁴

Is P unable to communicate their decision?

34. Any residual ability to communicate is enough, so long as P can make themselves understood. This will be an area where it is particularly important to identify (and to demonstrate you have identified) what steps you should be taking to facilitate communication: for instance, reproducing as best as possible the manner by which they usually communicate, providing all necessary tools and aids, and enlisting the support of any relevant carers or friends who may assist with communication.

¹³ [The PCT v P, AH & the Local Authority](#) [2009] EW Misc 10 (COP).

¹⁴ PC at paragraph 54.

(3): The Causative Nexus

35. In all cases, it is vital to consider whether this third question – the ‘causative nexus’ – is established. In other words, are you satisfied that the inability to make a decision is because of the impairment of the mind or brain? Any pro forma form for the assessment of capacity that does not include a final box asking precisely this question is likely to lead you astray. In *PC and NC v City of York Council* this issue made all the difference: that her inability “*significantly relate[d]* to” PC’s mild learning disability was insufficient: the MCA requires the inability to be “because of” the impairment, which is evidentially more stringent.
36. To reiterate, there has to be (and you have to show that you are satisfied why and how there is) a causal link between the disturbance or impairment and the inability to make the decision(s) in question. *JB’s* case, again, shows how easy it is to assume that merely because a person has schizophrenia, they are then unable to take decisions regarding surgical procedures – this is entirely incorrect.

D: Recording your assessment

37. A “good” capacity assessment would include the following considerations:

- (1) Be clear about the capacity decision that is being assessed;
- (2) Ensure P (and you) have the concrete details of the choices available (e.g. between living in a care home and living at home with a realistic package of care);
- (3) Identify the salient details P needs to understand/comprehend (ignoring the peripheral and minor details);
- (4) Avoid the protection imperative;
- (5) Demonstrate the efforts taken to promote P’s ability to decide;
- (6) Evidence each element of your assessment:
 - i. What is the impairment/disturbance? Is it temporary or permanent?
 - ii. Why could P not understand, or retain, or use/weigh, or communicate in spite of the assistance given?
 - iii. How is the inability because of the impairment/disturbance (as opposed to something else)?
- (7) Why is this an incapacitated decision as opposed to an unwise one?

38. In addition to the specific points mentioned above, as with all documentation, the key general points to remember are:

- Contemporaneous documentation is infinitely preferable to retrospective recollection;
- Do not assert an opinion unless it is supported by a fact;
- “Yes/No” answers are, in most cases, unlikely to be of assistance unless they are supported by a reason for the answer;
- What is reasonable to expect by way of documentation will depend upon the circumstances under which the assessment is conducted. An emergency assessment in an A&E setting of whether an apparently brain-injured patient has the capacity to run out of the ward into a busy road will not demand the same level of detail in the assessment or the recording as an assessment of whether a 90 year old woman has the capacity to decide to continue living in her home of 50 years where the concerns relate to her declining abilities to self-care.

E: Conclusion

39. Finally, as the court memorably put it in *JB*, “*do not allow the tail of welfare to wag the dog of capacity*”. An extremely foolish or irrational decision is still a decision and one that P is entitled to make. A decision can only be taken either in reliance on the general defence in s.5 MCA 2005 or by the court if and when it is proved on the balance of probabilities that (1) P is in fact unable to take the decision in question and (2) this inability is because of an impairment or disturbance in the functioning of the mind or brain.

F: Useful resources

40. Useful free websites include:

www.copcasesonline.com – database of case summaries and case comments from the monthly Thirty Nine Essex Street Mental Capacity Law Newsletter, to which a free subscription can be obtained by emailing marketing@39essex.com.

www.mclap.org.uk – website set up by Alex with forums, papers and other resources with a view to enabling professionals of all hues to ‘do’ the MCA 2005 better.

www.mentalhealthlawonline.co.uk – extensive site containing legislation, case transcripts and other useful material relating to both the Mental Capacity Act 2005 and Mental Health Act 1983. It has transcripts for more Court of Protection cases than any other site (including subscription-only sites), as well as an extremely useful discussion list.

www.scie.org.uk - Social Care Institute of Excellence, including good practice guidance in a number of areas relating to mental capacity and related law as well as a guide (Guide 42) to accessing the Court of Protection.

<http://www.gmc-uk.org/learningdisabilities/> - extremely useful resource designed in the first instance for doctors, but of much wider application, with particularly useful practical guidance upon communication techniques.